PAID CLAIMS AND ENCOUNTERS STANDARD 35C-FILE

DATA ELEMENT DICTIONARY, VERSION 1.9

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Click here to go to Document Revision Log

Department of Health Care Services (DHCS)
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DOCUMENT REVISION LOG

Version No.	Date	Requestor	Description
1.0	04/2002	Chander Arora	NEW
1.1	10/2003	Chander Arora	REVISED R01 – R15
1.2	06/2004	Chander Arora	REVISED R16 - R18
1.3	06/2005	Dave Winje	REVISED R19a,b
1.4	07/2005	Kelly Klemin	REVISED R20, 21
1.5	5/21/07	K Klemin, J Branston	REVISED
1.6	7/5/2007	K Klemin, J Branston	REVISED
1.7	10/31/07	J Cheung	REVISED
1.8	8/2008	S. Crabill	REVISED
1.8.1	11/2010	S. Crabill	REVISED
1.8.2	11/2011	K. Klemin	REVISED
1.9	6/2012	Michele Cox, D. Winje	REVISED

1.8 Document History (Version Control)

Version	Author, Dept	Brief Description of Modifications
1.5	Kelley Klemin, Julian Branston, ITSD	New data elements added
1.6	Kelley Klemin, Julian Branston, ITSD	Complete revision of 35C Data Dictionary, including code values for data elements and the Appendices. The new data element F35C-DRUG-PROCEDURE-CODE was also added. Acronym for DHS updated to DHCS in main body of the document, unless it relates to historical information. Further revisions are anticipated for the next release.
1.7	Julie Cheung, ITSD	Added NCPDP cross-reference for pharmacy claims reporting.
1.8	Steve Crabill, ITSD	Numerous revisions to complete updating the 35C Data Element Dictionary. New elements have been added.
1.8.1	Steve Crabill, ITSD	Revised Elements 93.1 and 93.3.
1.8.2	Steve Crabill, ITSD	Revised definition of CIN in Elements 6.0, 8.0, and Appendix A.
1.9	Steve Crabill, ITSD	Numerous revisions to Appendices J, P, & R. Added value 'D' to Billed Code Indicator.

TABLE OF CONTENTS

1.1 PREFACE

INTRODUCTION

Medi-Cal is the main source of health care coverage for millions of Californians, aiding the poor, elderly, disabled, and other populations access needed health services. A broad range of health care services are covered under Medi-Cal, including hospitalization and out-patient primary care, mental health, long-term care, nursing home, and dental services. Thousands of health care services and medical supplies providers prepare millions of claims and encounters records per month. Medi-Cal reimbursement to the health care providers is accomplished in one of three basic modes: either

- 'fee-for-service' based on a claim, claims adjudication, and the resulting paid or denied claim record; or
- a fixed rate per member per month, or capitation, for Medi-Cal beneficiaries enrolled in a Managed Care plan, reporting an 'encounter' record defining the health services provided; or
- funding reimbursement to another health program such as for Short-Doyle mental health services or for waivers such as for in-home community-based services, resulting in a 'paid claim' record for each service covered.

The Department of Health Care Services (DHCS) manages California's Medi-Cal program and the program's eligibility, scope of benefits, reimbursement, and related components. DHCS contracts with Fiscal Intermediaries (FIs) to process fee-for-service claims and requires the Managed Care contractors to provide encounter records. To obtain Medi-Cal funding, the waiver programs and Departments of Mental Health and Alcohol and Drug must submit claim records. DHCS collects and processes all of these records for the various purposes outlined later. The current DHCS FIs are Electronic Data Systems (EDS) and Delta Dental.

Records for the services paid for in part with federal financial participation funds (FFP) are collected. This includes claims processed by Electronic Data Systems (EDS), Delta Dental Services, the Departments of Mental Health (DMH) and Alcohol and Drugs, services provided under such managed care (capitation) models as County Organized Health Systems (COHS), geographic managed care (GMC), and two-plan counties.

The following list indicates uses of Paid Claim/Encounter data:

- Research
- Public Health Analysis & Policy Setting
- Program Management and Control
- Budgeting (Local Assistance and Admin Support)
- Rate Setting
- Fraud and Abuse (Surveillance, Restricted Services, Case Finding, Case Building, Court Documents, etc.)
- Audits
- Third Party Collections (Auto accidents, Estates, etc.)
- Medicaid funding for other Departments/Programs
    - Mental Health/ADP - Short Doyle
    - Waivers for DDS, AIDS etc.
- State and Federal Reporting
- Drug Rebate - Volume purchase information
- Comparing Health Models (FFS vs. Managed Care)
- Data Warehousing, Data Mining and drill down

PURPOSE AND USES OF THE DATA ELEMENT DICTIONARY

This Data Element Dictionary (DED) is provided to define and describe the Paid Claims/Encounter DataStream Standard 35-File. The DED is organized to reflect the order in which the data elements occur on the individual records of the file. Accordingly, the schematic of the record is shown first, followed by each data element in order. For each data element, it's name, definition, location on the file and allowed values are described. The reader may use the Table of Contents to select the page number of a data element and immediately transfer to the page in the DED where that data element's data definition begins.

The same basic document can assist researchers and other users of the Paid Claims/Encounters records, several appendices provide code values and historical information about the data elements. For ease of use, 'links' have been established to quickly refer to the associated 'history' information previously found to be helpful for analysts considering the PC/E data across past time periods.

DESCRIPTION OF THE 35-FILE STRUCTURE

The Paid Claims/Encounters (PC/E) DataStream Standard 35-file contains variable length records. Each record consists of a header section that is 470 characters in length followed by (0-99) detail segments that are each 310 characters long. The detail segments exist in two types: Main type and Compound Drug type.

Each Main type segment in a claim record contains information for a specific service (claim line) reported by the provider on a claim document or electronic claim record.

Each Compound Drug type segment in a claim record contains information for a specific ingredient in the compound drug, as well as information on the compound as a whole. There is one Compound Drug type segment for each ingredient in the compound. A compound drug claim record can contain information for only one compound drug prescription. A compound drug claim record normally has one, and only one, main type segment as the first detail segment, followed by 0-40 compound drug segments. The number of compound drug segments depends upon the compound drug number of ingredients. The segment count in the claim header is thus normally one more than the compound drug number of ingredients. A compound drug claim record can have a segment count of zero, with no detail segments.

Typically, claim records with a segment count of zero are Adjustment Claims.

DATA ELEMENT DESCRIPTIONS

This document contains a definition for each data element used in the PC/E DataStream Standard 35-file. The data element definitions are arranged in sequential order as they appear on the record layout.

The DED is designed to provide quick, easy access to the appropriate reference material. From the data element in the dictionary the reader can link to appropriate appendices for more detailed reference material. The reader can also link to historical data, if it exists, for each particular data element.

The Appendices provide a Glossary of terms used, explanation of codes used by data elements, historical and other relevant information.

The following information is generally available for each data element:

General Name
COBOL Name
Location on the record
Definition
Format description
Allowed values

Comments and special considerations
Revisions and History

The DED contains the following appendices:

DOCUMENT MAINTENANCE AND REVISIONS

As new or revised data elements are defined, the DED will be expanded to include them. A Revision Log at the beginning of the document contains the Version number, Date, Requestor and Description of the Changes.

Please send all corrections and updates or requests for more copies of this manual to:

Department of Health Care Services
Information Technology Services Division
Help Desk
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P.O. Box 942732
Sacramento, CA 942732

PROCEDURES TO CREATE AN INDEX

1) Create a 'Concordance.doc' Word document consisting of one Word table with two columns. The left column is the text item to be indexed. The right column is the index entry label under which the item will be shown. Please note that these entries are case-sensitive.

2) Go into the document to be indexed.

3) Under Tools > Options > View-Tab, ensure that:

- Field Codes are unchecked
- Hidden Text is checked
- All is unchecked

4) Go to the location in the document where the index is to be displayed.

5) Go to Insert > Index and Tables > Index-tab > AutoMark. Find and select the appropriate Concordance file. Now you should see which items in the text are marked for indexing.

6) Go to Tools > Options > View-Tab, and change All back to unchecked (to eliminate display of paragraph marks).

7) Go to Insert > Index and Tables > Index-Tab > Modify, and select Apply, followed by OK. The index should now be displayed in the document.

8) Go to Tools > Options > View-Tab, and change Hidden-Text to unchecked (to eliminate display of text markings).

Procedures To Update the Index When the Concordance File Has Been Modified.

1) Modify the contents of the Concordance file as needed. (The left column is the text item to be indexed. The right column is the index entry label under which the item will be shown. Please note that these entries are case-sensitive.)

2) Go into the document being indexed.

3) Go to Insert > Index and Tables > Index-tab > AutoMark. Find and select the appropriate Concordance file. You should now see updates to Concordance entries reflected in the marking of text items.

4) Go to Tools > Options > View-Tab, and change All back to unchecked (to eliminate display of paragraph marks).

5) Go to where the index is displayed and place your cursor within the displayed index. Press F9 to update. New Concordance entries should now be reflected in the displayed index.

6) If Concordance modifications included change to the labels under which text items are indexed (Concordance right-hand column), previous versions of these labels may still be in effect within the document and index due to old text markings still being present. You must manually delete old unwanted text markings. Then repeat step #5.

7) Go to Tools > Options > View-Tab, and change Hidden-Text to unchecked (to eliminate display of text markings).

PROCEDURES TO UPDATE TABLE OF CONTENTS AND THE INDEX

Note: Use this procedure after this file has been changed

1) Go to Table of Contents (TOC) right click, click on update field, select update entire field and then click ok.

2) Go to the index and pace your cursor in front of the first entry. Right click the click on update field.

PROCEDURES FOR MAINTAINING AN EMBEDDED RECORD LAYOUT

1) The record layout document (an embedded Word document), is hyperlinked to this document. To keep the source document in synch with a revised record layout document, delete the embedded

record layout link/object from this document above, and then embed a new (modified) record layout link/object into this document.

2) To change the way an embedded object appears, go to Edit > Worksheet-Object > Convert, and adjust the Display-As-Icon and/or Float-Over-text settings.

REFERENCE SOURCES FOR OTHER RELATED INFORMATION:

The following organizations have other data files, publications and reports that relate to the Medi-Cal program or health field in general.

STATE OF CALIFORNIA
Internet http://www.ca.gov/

Department of Finance
Demographic Research Unit
915 L St.
(916) **322-465**1
Internet: http://www.dof.ca.gov/html/Demograp/druhpar.htm
Information available: Population Estimates for California State and Counties.

Department of Health Care Services
Internet: http://www.dhcs.ca.gov/Pages/default.aspx

Medi-Cal Policy Institute
Internet: http://www.medi-cal.org/

FEDERAL GOVERNMENT
Department of Health and Human Services
Internet: http://www.os.dhhs.gov/

Centers for Disease Control and Prevention
Atlanta, Georgia
(202) **690-686**7
Internet: http://www.cdc.gov/

National Institutes of Health
(301) **496-400**0
Internet: http://www.nih.gov/

2.0 SEGMENT COUNT

COBOL Name:	F35C-SEGMENT-CNT	
Location on Record:	**003-004**	
Definition:	Segment Count identifies the number of fixed length detail segments appended to header segment of the record.	
Format Description:	Data Type:	Binary
	Display Length:	Up to 4
	Storage Length:	2
	Picture Clause:	S9(04) BINARY
Allowed Values:	00-99 Non-Adjustment claims must have at least one detail.	
Comments and Special Considerations:	There should be one main type detail segment for each service reported by the provider on a claim document or electronic claim record. Compound drug claims can be submitted in either of two methods: 1)Report all ingredients: This is the method that will be used for fee for service claims processed by EDS. In this method a compound drug claim record normally has one, and only one, main type segment as the first detail segment, followed by 0-40 compound drug segments. The number of compound drug segments depends upon the compound drug number of ingredients. The segment count in the claim header is normally one more than the compound drug number of ingredients. In this method only one compound drug can be reported per claim record. A compound drug claim record can have a segment count of zero with no detail segments. Typically, claim records with a segment count of zero are adjustment claims. 2)Report the most expensive element: This is the method that will be used for claims other than those in 1) above. In this method a compound drug claim will have one main segment for each compound drug and that segment will report only the most expensive ingredient used in the compound drug. Using this method as many as 99 compound drugs could be reported on a single claim. If there is no detail, the claim is an adjustment claim. See Adjustment Indicator for more information. For claims other than 1) above, the number of main type details (if greater than zero) on a pharmacy claim corresponds to the number of prescriptions. Encounter claims can have up to 22 details. Each hospital claim must have at least one detail. If there are more than 22 detail segments, a new Encounter claims record must be started with a new ICN/CCN. See Appendix A, F35C-SEGMENT-CNT-COUNT-EDIT, for more information.	
Revisions and History:	**Date**	**Description**

3.0 PLAN CODE

COBOL Name:	F35C-PLAN-CODE	
Location on Record:	**005-006**	
Definition:	Plan Code identifies the specific fiscal intermediary that processed the claims.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)

Allowed Values:

00	Delta Dental Services (DELTA)
01	%Department of Developmental Services Waiver Program
01	%Department of Social Services Personal Care Services
02	Encounter Data
01,02,04	Medi-Cal Intermediary Operations (MIO) (through November 1980)
03	Formerly used by Redwood Health Foundations (RHF) (Their contract to create Long Paid Claims ended 6/89.)
04	County Operated Health Systems (COHS) (*Santa Barbara Health Initiative (SBHI), Marin County, *Santa Cruz County Health Options (SCCHO), *+Napa County, *+Solano County, *Cal Optima (Orange county), *Health Plan of San Mateo (HPSM), Yolo County, Monterey County)
05	&Early Periodic Screening, Diagnosis and Treatment (EPSDT)
06	!State Hospitals/State Developmental Centers (DDS is their claims processor.) (Also called Department of Mental Hygiene (DMH)
08	Short-Doyle/Medi-Cal (SD/MC) (Also called Medi-Cal Short/Doyle) Department of Mental Health and Department of Alcohol and Drugs create the data the MSD system uses to create these claims.)
09	Electronic Data Systems (EDS)
09	@Electronic Data Systems (EDS) Mental Health Inpatient
29	EDS: As of Dec,06 Aid code 8H (FPACT) has been assigned '29'.

Notes:

% To determine which department is which, use Vendor Code '89' for the Department of Social Services Personal Care Services Program. Use Vendor Code '76' for the Department of Developmental Services Waiver Services.

***** To determine which county health initiative (plan code 4) is which, use the county code to make the determination or use the recipient HCP code (a.k.a. PHP Code).

+ See Plan Code in Appendix G, DATA ELEMENT HISTORY.

& EPSDT is the Federal program name. In California it is known as Child Health and Disability Prevention Program (CHDP), which is maintained and processed by EDS. These are created claims just like the SD/MC claims.

***** See Plan Code in Appendix G, DATA ELEMENT HISTORY.

! See Plan Code in Appendix G, DATA ELEMENT HISTORY.

@ The EDS Mental Health inpatient claims can be determined by using the first three characters of the Provider Number. It always starts with HSM for hospital Mental health. Vendor Code 63 also identifies these claims.

Comments and Special Considerations:

See Appendix D, Comparison of Paid Claims Fields for Various Plan Codes for an overview of various plan codes fields interrelationships.

See Appendix A, F35C-PLAN-CODE for more information.

Revisions and History:

Date	Description

	For the history of this data element, see Data Element History.	

4.0 CLAIM TYPE

COBOL Name:	F35C-CLAIM-TYPE	
Location on Record:	**007-007**	
Definition:	DHCS Claim Type identifies the general type of service that was rendered.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	DHCS Claim Type 1 = Outpatient 2 = Inpatient 3 = Pharmacy 4 = Medical/Physician 5 = Dental 6 = EPSDT/CHDP	
Comments and Special Considerations:	Only Delta Dental creates claim type 5. Claim type 6 is used only on claims reformatted from the EPSDT claim files. For our purposes to determine if the claim is a crossover, you must check the Medicare Indicator. See Medicare Indicator. Vendor Code 83 (Pediatric Subacute Rehab/Weaning) is found on Claim Type 2, but in this unique case, the reported Days Stay and Units of Service are not inpatient days. When counting inpatient days for long term care, the days reported for Vendor Code 83 should not be included. See Appendix D, Comparison of Paid Claims Fields for Various Plan Codes for an overview of various plan codes' fields interrelationships. Information related to FI (Fiscal Intermediary) can be found in DHCS CLAIM TYPE, Appendix K. See Appendix A, F35C-CLAIM-TYPE-EDIT for more information	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, History of Claim Type.	

5.0 CLAIM CONTROL NUMBER (CCN)

COBOL Name:	F35C-CCN	
Location on Record:	**008-014**	
Definition:	Claim Control Number (CCN), also known as Internal Control Number (ICN) uniquely identifies any processed claims within a specific plan code.	
Format Description:	Data Type:	Packed
	Display Length:	13
	Storage Length:	7
	Picture Clause:	S9(13) COMP-3

Allowed Values:

Plan Code	Source	Format
00	DELTA	YYYYJJJSSSSSS
01,02	MIO	AAYYJJJBBBSSS
01	DDS Waiver	YYJJJNNNNNNNN (Sequential starts w/000000001)
01	DSS PCSP	YYJJJ00000000
02	Encounter	YYJJJNNNNNNNN
04	Monterey	YYJJJNNNNNNNN
04	Napa	28YYJJJBBBSSS
04	Orange	YJJJRRFFSSSLL (non pharmacy claims – claim type not equal 3)
04	Orange	30YYJJJBBBSSS (pharmacy claims – claim type equal 3)
04	San Mateo	41YYJJJBBBSSS
04	Santa Barbara	YYJJJNNNNNNNN
04	Santa Cruz	YYJJJNNNNNNNN
04	Solano	48YYJJJBBBSSS
04	Yolo	57YYJJJBBBSSS
05	EPSDT	YYJJJSSSS0000
06	DDS	HHCCCCCCCYYMM
08	S/D	YYJJJ00000000
09	EDS	YJJJRRFFSSSLL

Format Values

Code	Value
A	COUNTY/AREA/REGION
B	BATCH NUMBER
C	CASE NUMBER
F	MICROFILM ROLL SEQUENCE NUMBER
H	DDS PROVIDER NUMBER
J	JULIAN DATE
L	LINE NUMBER
M	MONTH
N	NUMBER
R	EDS' MICROFILM ROLL NUMBER
S	SERIAL NUMBER
Y	YEAR
0	ZERO

Comments and Special Considerations:	The purpose of the ICN is for a data source to be able to locate that particular claim in their system. If the originating claim is needed, that number should make it easy to identify it. Also, within the ICN, the Julian date that the data source received the claim is needed. It can be used to calculate length of time from service to claim received for processing or from received to processed. This field is also referred to as CCN because it is called Claim Control Number (CCN) by EDS. The format of the ICN is dependent on the data source and contains the year and Julian date. See Plan Code. Information concerning roll numbers related to the FI (EDS) can be found in CLAIM CONTROL NUMBER, Appendix K. See Appendix A, F35C-CCN-Edit for more information.	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, CLAIM CONTROL NUMBER	

6.0 BENEFICIARY ID NUMBER

COBOL Name:	F35C-BENE-ID	
Location on Record:	**015-028**	
Definition:	Beneficiary Identification identifies a specific individual.	
Format Description:	Data Type:	Character
	Display Length:	14
	Storage Length:	14
	Picture Clause:	X(14)
Allowed Values:	Alphanumeric CO = County AC = Aid Code 9 = MEDS ID or SSN follows C = CIN follows M = MEDS ID or SSN follows A = Alphabetic (or numeric) J = CTP's pre-imprinted number from paper claim form K = CTP's pre-imprinted number from paper claim form N = Numeric F = Family budget unit (FBU) P# = Person Number CO AC 9 NNNNNNNNN SSI/SSP with aid code of 10, 20 or 60 CO AC 9 NNNNNNNNN non-SSI/SSP without aid code of 10, 20 0r 60 CO ACM NNNNNNNNN M with SSN used CO ACM 8NNNNNNNP M with MEDS ID with pseudo MEDS ID starts with 8 CO ACM 9NNNNNNNP M with MEDS ID with pseudo MEDS ID starts with 9 CO AC C NNNNNNNNA C and then CIN CO AC NNNNNNN F P# County defined Bene ID 19 AC AAAAAAA F P# LA county defined Bene ID can have alphas 19 AC 9AAAAAA F P# LA county series number can start with a 9 59 00 NNNNNN CCS CO is always 59 and IDS end with letter CCS CO 9H 9 9NNNNNNNA SD/MC Healthy Families with 9 and then CIN CO 94 M NNNNNNNNJ Children's Treatment Program with # from form CO 94 M NNNNNNNNK Children's Treatment Program with # from form	
Comments and Special Considerations:	The identification number may either be assigned by the MEDS for Social Security Administration's Supplemental Security Income/Supplemental Security Payment (SSI/SSP) eligible or county welfare departments (for AFDC cash assistance and various medical assistance only programs). There are five different types of Beneficiary Identification (BID)/Bene ID numbers, with various components. The number assigned by MEDS for Social Security Administration (SSA) consists of the 2 digit county code, 2 digit aid code, a '9' in the fifth digit, and the person's Social Security Number. If the person moves, MEDS will only need to update the county. The only valid aid codes are the SSI/SSP aid codes 10, 20 and 60. It should be noted that providers will bill using a '9' in the 5th digit and the aid code is not 10, 20, or 60. Frequently you can see the aid codes starting with 1, 2, or 6 since these persons were dropped from SSI/SSP but retain no-cost Medi-Cal eligibility until the responsible county can determine if they are eligible under a Medi-Cal only program.	

On the other hand, county assigned numbers are county specific. That is, if a person moves to another county he/she transfers eligibility and receives a new BID number. The number consists of the 2 digit county code, 2 digit aid code, 7 digit county defined case number, 1 digit Family Budget Unit (FBU), and a 2 digit Person Number. Sometimes the Family Budget Unit is alphabetic.

With the implementation of LA county's Los Angeles Eligibility Automated Determination Evaluation Report (LEADER) system, the serial number can contain many alphabetic letters. Their meaning is only known to the LEADER system. The person number will be numeric though.

Within a given county a person may change eligibility status (aid code) while retaining the same basic BID number. That is, the person might go from AFDC-cash grant (aid code 30) to AFDC-medically needy share of cost (aid code 37) with the BID reflecting only the aid code change. In addition to the above two formats, some fiscal intermediaries and providers who bill Medi-Cal are using another format consisting of the 2 digit county code, 2 digit aid code, an 'M' + SSN number or pseudo SSN number. A pseudo SSN is a MEDS assigned number that starts with an '8' or a '9' and ends with a 'P'. Note when working with Medicare Crossover Claims: This may OR may not be the Medicare number for that individual. Medicare numbers CAN be different from regularly assigned SSA numbers.

Also note, some providers bill using a '9' or 'M', almost what appears to be interchangeable, so if you see a '9' do not assume it is a Crossover Medi-Care claim. Check the aid code for 10, 20 or 60 to make that determination.

Starting March 1994, California started using plastic State of California Benefits Identification Cards (BICs) for beneficiaries throughout the state. Note: Recipient card ownership does not guarantee eligibility. That must be verified though the Point of Service (POS) device, Claims and Eligibility Real-Time System (CERTS) PC software, AEVS or Third Party software that has been written to allow providers to access Medi-Cal eligibility information. The format is similar to the pseudo BID number and consisting of the 2 digit county code, 2 digit aid code, a 'C' + Client Index Number (CIN). The CIN is defined as NNNNNNNNA. It has 8 numeric digits and ends with an alpha character of: A, C through H, M, N, or S through W. These characters are invalid endings for CINs: B, I, J, K, L, O, P, Q, R, X, Y, and Z. Note that CINs never end with a 'P' and therefore cannot be confused with Pseudo SSNs. CINs are cross-referenced to MEDS IDs in the MEDS system.

Starting with the May 20th, 1999 cut off, California's Healthy Families Program was implemented in the Medi-Cal Health. Since SSNs are not required for billing, a new ID had to be developed. It was decided to use another pseudo BID number and it consists of the 2 digit county code, 9H (the HFP aid code) or 7X (the HFP Bridge code), an '9' + Client Index Number (CIN). EDS claims do not have this requirement, so this format will never be seen on the claims they process.

See Appendix A, F35C-BENE-ID-Edit for more information.

Refer to Beneficiary ID Number for MEDS and County assigned numbers.

Revisions and History:

Date	Description
November, 2011	Modified definition of CIN.
For the history of this data element, see Appendix G, BENEFICIARY ID NUMBER.	

7.0 SSN OR MEDS ID

COBOL Name:	F35C-SSN-OR-MEDS-ID	
Location on Record:	**029-037**	
Definition:	This field contains the client's SSN or a MEDS-assigned pseudo-ID.	
Format Description:	Data Type:	Character
	Display Length:	9
	Storage Length:	9
	Picture Clause:	X(09)
Allowed Values:	For SSN, all 9 characters are numbers. For Pseudo-ID, first byte is an '8' or '9', and last byte is a 'P'.	
Comments and Special Considerations:	This field may contain a pseudo meds ID (first digit is either number 8 or 9 and the last digit is the letter 'p'. Example:'8xxxxxxxp'or '9xxxxxxxp'). This field is generated by MEDS. DHS historically also ran a cross-reference program to put the right serial number on a claim, but that will be discontinued sometime in 2002. As of 1988 a provider can bill with many variations of the 14 character Bene ID or just the CIN or MEDS ID. See Appendix A, F35C-SSN-OR-MEDS-ID-Edit for more information. For more information on FI, see SOCIAL SECURITY **NUMBER**, Appendix K. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 332-CY, 'Patient ID'	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, SOCIAL SECURITY NUMBER	

8.0 BENE CLIENT INDEX NUMBER

COBOL Name:	F35C-BENE-CLIENT-INDEX-NUMBER	
Location on Record:	**038-046**	
Definition:	Client Index Number identifies a beneficiary using a unique assigned number.	
Format Description:	Data Type:	Character
	Display Length:	9
	Storage Length:	9
	Picture Clause:	X(09)
Allowed Values:	CIN is defined as NNNNNNNNA. It has 8 numeric digits and ends with an alpha character of: A, C through H, M, N, or S through W. These characters are invalid endings for CINS: B, I, J, K, L, O, P, Q, R, X, Y, and Z. Note that CINS never end with a 'P' and therefore cannot be confused with pseudo SSNS.	
Comments and Special Considerations:	CINs are cross-referenced to MEDS IDs in the MEDS system using the CIN cross-reference file. DHS historically also ran a cross-reference program to put the right serial number on a claim, but that will be discontinued sometime in 2002. As of 1988 a provider can bill with many variations of the 14 character Bene ID or just the CIN or MEDS ID. See Appendix A, F35C-BENE-CIN-Edit for more information.	
Revisions and History:	**Date**	**Description**
	Nov., 2011	Modified the definition of CIN.
	For the history of this data element, see Appendix G, History of CIN	

9.0 BENEFICIARY NAME

COBOL Name:	F35C-BENE-NAME	
Location on Record:	**047-061**	
Definition:	Beneficiary Name identifies Medi-Cal recipient by name.	
Format Description:	Data Type:	Character
	Display Length:	15
	Storage Length:	15
	Picture Clause:	X(15)
Allowed Values:	Alpha numeric	
Comments and Special Considerations:	Left justify field with the following format: LLLLLLLLLLLLFFF For more information on FI, see BENEFICIARY **NAME**, Appendix K. See Appendix A, F35C-BENE-NAME-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 716, 'Last Name', 717, 'First Name'	
Revisions and History:	**Date**	**Description**

10.0 SEX (GENDER)

COBOL Name:	F35C-BENE-SEX	
Location on Record:	**062-062**	
Definition:	Sex identifies the Sex of the Beneficiary (also referred to as Gender).	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	1 or M = Male 2 or F = Female Space = Not Reported	
Comments and Special Considerations:	For more information on FI, see FI Sex, Appendix K. See Appendix A, F35C-BENE-SEX-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 305-C5, 'Patient Gender Code'	
Revisions and History:	**Date**	**Description**

11.0 ETHNICITY (RACE)

COBOL Name:	F35C-BENE-RACE	
Location on Record:	**063-063**	
Definition:	Ethnicity identifies ethnicity of beneficiary. This coding scheme is used on MEDS.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Codes used by MEDS Space Unknown (This code is not on MEDS) 0 Unknown 1 White 2 Hispanic 3 Black 4 Other Asian or Pacific Islander 5 Alaskan Native or American Indian 7 Filipino 8 No Valid Data Reported (MEDS generated) 9 No response, client declined to state A Amerasian (Children of Southeast Asian mothers and American citizen fathers. This is a subset of Vietnamese.) C Chinese H Cambodian J Japanese K Korean M Samoan N Asian Indian P Hawaiian R Guamanian T Laotian V Vietnamese Z Other	
Comments and Special Considerations:	For more information on FI, see FI Ethnicity, Appendix K. See Appendix A, F35C-BENE-RACE-Edit for more information.	
Revisions and History:	**Date**	**Description**
	6/27/2007	Updated from the MEDS Quick Reference Guide
	For the history of this data element, see Appendix G, History of Ethnicity	

12.0 BENEFICIARY HIC

COBOL Name:	F35C-BENE-HIC	
Location on Record:	**064-075**	
Definition:	Beneficiary HIC (Health Insurance Claim) number identifies Medi-Cal recipient's Medicare coverage identification number.	
Format Description:	Data Type:	Character
	Display Length:	12
	Storage Length:	12
	Picture Clause:	X(12)
Allowed Values:	Alphanumeric, or space	
Comments and Special Considerations:	The HIC can contain two kinds of numbers. One is the Railroad Retirement Board Claim Number. Individuals whose primary employment has been with the railroad use it. It is either a six or nine digit number with an alphabetic prefix. The SSA computer system changes it so that it looks like a pseudo SSN number. Please see the State Data Exchange documentation for more information. The other kind of HIC number is the SSN with suffix that describes how that person is related to the SSN. If the suffix is an 'A', then it is the wage holder's SSN. If the suffix is a 'B' the person is a wife. If the suffix is a 'C' the person is a child. Numbers are assigned after the suffix to describe which wife or child. There are also other suffixes too numerous to describe here. Please refer to the BENDEX (Beneficiary Data Exchange) documentation for more information.	
Revisions and History:	**Date**	**Description**

13.0 PROVIDER ZIP CODE

COBOL Name:	F35C-PROVIDER-ZIP-CODE	
Location on Record:	**076-084**	
Definition:	Provider Zip Code identifies the geographical location of the provider.	
Format Description:	Data Type:	Character
	Display Length:	9
	Storage Length:	9
	Picture Clause:	X(09)
Allowed Values:	Alphanumeric or space.	
Comments and Special Considerations:	This is about the only way to identify out-of-state providers. For all practical purposes EDS will process out-of-state provider claims. For the United states ZIP codes, the main 5 characters are left justified and the next 4 characters are zero or the real assigned zip code value. For the Canadian Postal Codes, the 6 character codes are not kept in the EDSNET provider file's zip code field. They are kept in the city field and the zip code is all zeros. EDSNET lists the state code as CN. For the Mexican Postal Codes, the 6 character codes are left justified and zero filled at the end if the code is known. Otherwise the postal code is all zero filled. EDSNET list the state code as MX. Some providers have more than one zip code. This happens especially for hospitals. The hospital itself has its own, but the billing department may be in another zip code. The hospital may have satellite offices also for their outpatient clinics like radiology, mental health, OB/GYN, etc. If the satellite location bills, they may have a different zip code than the main facility. It also happens that the provider zip code is their billing location's zip code, not the physical location where the provider renders services to the beneficiaries. Not present on DDS, SD/MC or EPSDT claims. For more information on FI, see FI Provider ZIP Code, Appendix K. See Appendix A, F35C-PROVIDER-ZIP-CODE-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 730, 'Zip/Postal Code'	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, Provider ZIP Code.	

14.0 PROVIDER NUMBER

COBOL Name:	PROVIDER-NUMBER	
Location on Record:	**085-094**	
Definition:	The provider number of the billing provider	
Format Description:	Data Type:	Character
	Display Length:	10
	Storage Length:	10
	Picture Clause:	X(10)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:	This field can contain NPI or other provider numbers such as the Medi-Cal provider number. Provider numbers are assigned primarily to facilitate billing activities, so a 'provider' may have multiple ID numbers. For example, a hospital might have an inpatient number, outpatient number and a long term care number. There is some standardization, such as long-term care numbers beginning LTC, but there are many exceptions. The individual physician numbers have a feature which distinguishes how many offices s/he has: Right most position = 0 = the physician works for a group provider Right most position = 1 = one office Right most position = 2 = two offices, etc. See Appendix Q, Provider Naming/Number System for the list of provider naming and number acronyms. Information related to FI can be found in FI Provider Number, Appendix K. See Appendix A, F35C-PROVIDER-NUMBER-Edit for more information. **Note:** These code values may become obsolete through NPI. `Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 201-B1,'Service Provider ID'` Pharmacy Claims: Provider ID can be NPI Medi-Cal Provider ID or NCPDP Provider ID number until full implementation of National Provider ID (NPI), scheduled for May 2008.	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, PROVIDER NUMBER.	

15.0 BILLING PROVIDER TAXONOMY

COBOL Name:	F35C-BILLING-PROVIDER-TAXONOMY	
Location on Record:	**095-104**	
Definition:	This field contains the taxonomy of the billing provider. The Health Care Provider Taxonomy code set is a collection of unique alphanumeric codes, ten characters in length. The code set is structured into three distinct "Levels" including Provider Type, Classification, and Area of Specialization.	
Format Description:	Data Type:	Character
	Display Length:	10
	Storage Length:	10
	Picture Clause:	X(10)
Allowed Values:	See the list of codes in the website below.	
Comments and Special Considerations:	Health Care Provider Taxonomy code list (provider specialty code) is available on the Washington Publishing Company web site: http://www.wpc-edi.com/content/view/515/229. The Blue Cross Blue Shield Association and ASC X12N TG2 WG15 maintains this taxonomy. See Appendix A, F35C-BILLING-PROVIDER-TAXONOMY-Edit for more information.	
Revisions and History:	**Date**	**Description**

16.0 BILLING PROVIDER OWNER NUMBER

COBOL Name:	F35C-BILL-PROVIDER-OWNER-NUM	
Location on Record:	**105-106**	
Definition:	The billing provider is the pharmacy or hospital that is billing the health care plan. The Provider Owner Number is a unique identifier of an owner. The identifier of the owner remains constant with new owners having the next higher sequential number.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	00-99 and spaces.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

17.0 BILLING PROVIDER LOCATION NUMBER

COBOL Name:	F35C-BILL-PROVIDER-LOCATN-NUM	
Location on Record:	**107-109**	
Definition:	The provider service location number is a sequential identifier which allows unique identification of an individual billing provider service location address.	
Format Description:	Data Type:	Character
	Display Length:	3
	Storage Length:	3
	Picture Clause:	X(03)
Allowed Values:	000 thru 999	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

18.0 PROVIDER COUNTY

COBOL Name:	F35C-PROVIDER-COUNTY
Location on Record:	**110-111**
Definition:	Provider County identifies the location of the provider's practice.
Format Description:	Data Type: Character Display Length: 2 Storage Length: 2 Picture Clause: X(02)

Allowed Values:

CODE	CMSP	COUNTY	CODE	CMSP	COUNTY
01		Alameda	30		Orange
02	Y	Alpine	31		Placer
03	Y	Amador	32	Y	Plumas
04	Y	Butte	33		Riverside
05	Y	Calaveras	34		Sacramento
06	Y	Colusa	35	Y	San Benito
07		Contra Costa	36		San Bernardino
08	Y	Del Norte	37		San Diego
09	Y	El Dorado	38		San Francisco
10		Fresno	39		San Joaquin
11	Y	Glenn	40		San Luis Obispo
12	Y	Humboldt	41		San Mateo
13	Y	Imperial	42		Santa Barbara
14	Y	Inyo	43		Santa Clara
15		Kern	44		Santa Cruz
16	Y	Kings	45	Y	Shasta
17	Y	Lake	46	Y	Sierra
18	Y	Lassen	47	Y	Siskiyou
19		Los Angeles	48	Y	Solano
20	Y	Madera	49	Y	Sonoma
21	Y	Marin	50		Stanislaus
22	Y	Mariposa	51		Sutter
23	Y	Mendocino	52	Y	Tehama
24		Merced	53	Y	Trinity
25	Y	Modoc	54		Tulare
26	Y	Mono	55	Y	Tuolumne
27		Monterey	56		Ventura
28	Y	Napa	57		Yolo
29	Y	Nevada	58	Y	Yuba
99		Out of State			

Y means that the county is a County Medical Services Program (CMSP) county (as of August 1998).

Comments and Special Considerations:

For more information on FI, see FI Provider County, Appendix K.

See Appendix A, F35C-PROVIDER-CNTY-Edit for more information.

Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 887, 'Service Provider County Code'

Revisions and History:

Date	Description

19.0 PROVIDER SPECIALTY

COBOL Name:	F35C-PROVIDER-SPECIALTY	
Location on Record:	**112-113**	
Definition:	Provider Specialty identifies the reported area of specialization for Physician/Medical and Outpatient claims.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	0-9, or space. See Physician Specialty Codes, Appendix P, for a list of Physician Specialty codes.	
Comments and Special Consideration:	It is on EDS, SBHI, HPSM, DELTA and Encounter claims. It is not on DDS, DSS, or SD/MC. This item is as declared by the physician when obtaining a provider number. See Appendix A, F35C-PROVIDER-SPECIALTY-Edit for more information. Applies only to Vendor Codes 20 and 22 and FI Provider Type Codes 22 and 26. For more information on FI, see PROVIDER SPECIALTY, Appendix K.	
Revisions and History:	**Date**	**Description**

20.0 REIMBURSEMENT RATE

COBOL Name:	F35C-REIMBURSEMENT-RATE	
Location on Record:	**114-116**	
Definition:	Reimbursement Rate identifies the percentage rate in which allowed charges will be adjusted to reflect the variance between charges and actual cost for out-of-state and non-contract hospitals.	
Format Description:	Data Type:	Numeric
	Display Length:	3
	Storage Length:	3
	Picture Clause:	9(03)
Allowed Values:	Numeric	
Comments and Special Considerations:	EDS files have 100 in this field for in-state claims. Monterey files have 100 in this field for all of claim types they bill for (1, 2, 3, and 4). DDS, DSS, and Encounter files all contain Zeros in this field. Applies to out-of-state and non-contract hospital inpatient claims. If the hospital is contracted with the state of California, the percentage rate is 100.	
Revisions and History:	**Date**	**Description**

21.0 SPECIAL PROCESSING TYPE

COBOL Name:	F35C-SPECIAL-PROCESSING-TYPE	
Location on Record:	**117-117**	
Definition:	This code is used to identify special processing needs that are currently identified through the use of the provider prefix.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Alpha	
Comments and Special Considerations:	**Special Processing Type Codes** A Rural Health Adult Day Health Care B Bypass Rate Update C CCS Medical Therapy Unit D Exclude from Automated Deactivation E Lab Reservation Exemption F Federally Qualified Health Clinic – Free Standing G Federally Qualified Health Clinic – Provider Based M Medically Indigent L LA Waiver - Outpatient Only P Bypass Prorated Pricing S Licensed Clinical Social Worker R Rural Health Clinic – Free Standing T TAR Exempt U Rural health Clinic – Provider Based W 1115 Waiver – Outpatient Only See Appendix A, F35C-SPECIAL-PROCESSING-TYPE-Edit for more information.	
Revisions and History:	**Date**	**Description**
	6/1/2007	New data element.

22.0 SPECIAL PROGRAM TYPE

COBOL Name:	F35C-SPECIAL-PROGRAM-TYPE	
Location on Record:	**118-118**	
Definition:	This code is used to identify a special program where the pricing for a revenue code may vary. This code will also be used for reporting of these special programs.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:	**Special Program Type Codes** W = 1115 Waiver L = LA Waiver - Inpatient Only 1 = IHSS State Plan (PCSP) 2 = IHSS Plus (1115 Waiver) 3 = IHO Personal Care Services (WPCS) See Appendix A, F35C-SPECIAL-PROGRAM-TYPE-Edit for more information.	
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

23.0 COBA ID

COBOL Name:	F35C-COBA-ID	
Location on Record:	**119-123**	
Definition:	Crossover carrier code field; used to determine which Medicare contractor is paid.	
Format Description:	Data Type:	Character
	Display Length:	5
	Storage Length:	5
	Picture Clause:	X(05)
Allowed Values:	Alphanumeric; list per the HCPCS Level 2 CMS code set .	
Comments and Special Considerations:	A crossover carrier code field which identifies which Medicare contractor is paid. See Appendix A, F35C-COBA-ID-Edit for more information.	
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

24.0 PAYER SEQUENCE CODE

COBOL Name:	F35C-PAYER-SEQUENCE-CODE	
Location on Record:	**124-124**	
Definition:	The payer sequence code identifies the insurance carrier level of responsibility for a payment of a claim.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Alpha (P, S, or T)	
Comments and Special Considerations:	P = Primary S = Secondary T = Tertiary	
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

25.0 VENDOR CODE

COBOL Name:	F35C-VENDOR-CODE	
Location on Record:	**125-126**	
Definition:	Vendor Code identifies the general type of provider.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Valid vendor code values 01 through 99.	
Comments and Special Considerations:	Please refer to Appendix V, Vendor Codes for the current list of vendor codes. See Appendix A, F35C-VENDOR-CODE-Edit for more information.	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, VENDOR CODE.	

26.0 DISCHARGE CODE

COBOL Name:	F35C-DISCHARGE-CODE	
Location on Record:	**128-128**	
Definition:	DHCS Discharge/Patient Status Code Indicates status of patient on last day of service on inpatient claims.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	DHCS Discharge/Patient Status: 1. Transfer to another hospital 2. Transfer to long term care (prior to 4/1/96). Transfer to Transitional Inpatient Care (effective 4/1/96) 3. Transfer to long term care 4. Discharge-deceased 5. Discharge to home 6. Still a patient 7. Transfer to long term care (obsolete) 8. Leave of absence 9. Transfer to board (obsolete) The DDS Patient Status Coding for Plan Code 6 claims is entirely different: 0. Still a patient 7. Transferred 8. Discharged 9. Discharge Deceased	
Comments and Special Considerations:	See Discharge Date because these two fields are related. For more information on FI, see DHCS DISCHARGE/PATIENT STATUS CODE, Appendix K. See Appendix A, F35C-DISCHARGE-CODE-Edit for more information.	
Revisions and History:	**Date**	**Description**
	6/15/2007	DDS codes updated
	For the history of this data element, see Appendix G, DISCHARGE/PATIENT STATUS CODE.	

27.0 SURGERY CODE

COBOL Name:	F35C-SURGERY-CODE	
Location on Record:	**130-130**	
Definition:	Surgery code identifies whether or not surgery was performed.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	S Surgery was performed. Space No Surgery was performed.	
Comments and Special Considerations:	See INPATIENT PRIMARY SURGERY CODE and INPATIENT SECONDARY SURGERY CODE for more information. For medical/physician, outpatient, vision, and crossover claim types, the procedure code is checked to determine if the surgery code should be set to an 'S'. This field is not used by SD/MC, DDS, DSS, EPSDT, and DELTA. This field was set to 'S' on 3 of the 3 Encounter inpatient claims from the March 2000 file, even though they had no segments. The primary and secondary surgery codes were also not found on EDSNET, so the Encounter files must have their own unique coding scheme. For more information on FI, see FI Surgery Code, Appendix K. See Appendix A, F35C-SURGERY-CODE-Edit for more information.	
Revisions and History:	**Date**	**Description**

28.0 MEDICARE INDICATOR

COBOL Name:	F35C-MEDICARE-INDICATOR	
Location on Record:	**131-131**	
Definition:	Medicare Indicator indicates that this was a Medicare Crossover claim.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	1 Medicare Involvement Present Space No Medicare Involvement	
Comments and Special Considerations:	The Medicare Indicator is not provided for EPSDT, SD/MC or Delta claims. DDS, DSS, and Encounter data show only spaces in this field. For more information on FI, see MEDICARE INDICATOR, Appendix K. See Appendix A, F35C-MEDICARE-INDICATOR-Edit for more information.	
Revisions and History:	**Date**	**Description**

29.0 ADMISSION DATE

COBOL Name:	F35C-ADMISSION-DATE	
Location on Record:	**132-139**	
Definition:	Admission Date identifies the date that the client was admitted to the facility on inpatient claims	
Format Description:	Data type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)
Allowed Values:	CCYYMMDD, where: CC = Century YY = Year MM = Month DD = Day	
Comments and Special Considerations:	For more information, see ADMISSION DATE, Appendix K. See Appendix A, F35C-ADMISSION-DATE-Edit for more information.	
Revisions and History:	**Date**	**Description**

30.0 DISCHARGE DATE

COBOL Name:	F35C-DISCHARGE-DATE	
Location on Record:	**140-147**	
Definition:	Discharge Date identifies the date that the client was discharged from the facility on inpatient claims	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)
Allowed Values:	CCYYMMDD, where: CC = Century YY = Year MM = Month DD = Day	
Comments and Special Considerations:	For more information, see DISCHARGE DATE, Appendix K. See Appendix A, F35C-DISCHARGE-DATE-Edit for more information.	
Revisions and History:	**Date**	**Description**

31.0 CHECK DATE

COBOL Name:	F35C-CHECK-DATE	
Location on Record:	**148-155**	
Definition:	Check Date identifies the date of the checks that paid the provider for the claim	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)
Allowed Values:	CCYYMMDD, where: CC = Century YY = Year MM = Month DD = Day	
Comments and Special Considerations:	This date is usually referred to as the month of payment/warrant date. The Check Date (date of payment) must be equal to or later than the adjudication date. Note: CHECK DATE is not necessarily the actual date of the check. And therefore may not indicate the month of payment (MOP) in all cases. Note: We always call Check Date as Date of Payment Information related to FI can be found in Appendix K, FI Check Date Go to Appendix A, F35C-CHECK-DATE-Edit to see edits. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 213, 'Billing Cycle End Date'	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, CHECK DATE.	

32.0 ADJUDICATION DATE

COBOL Name:	F35C-ADJUDICATION-DATE	
Location on Record:	**156-163**	
Definition:	Adjudication Date identifies the date upon which a claim was adjudicated.	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)
Allowed Values:	CCYYMMDD, where: CC = Century YY = Year MM = Month DD = Day	
Comments and Special Considerations:	For Encounter claims, if the records resulted from a capitated service, then the date used was the date the record was processed by the health plan. If the record resulted from a service provided as a non-capitated, fee for service arrangement, the date entered is when the health plan determined to pay for the reported service or supply. See Appendix A, F35C-ADJUDICATION-DATE-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 578, 'Adjudication Date'	
Revisions and History:	**Date**	**Description**

33.0 PATIENT LIABILITY

COBOL Name:	F35C-PATIENT-LIABILITY	
Location on Record:	**164-168**	
Definition:	Patient Liability identifies the amount owed by the recipient for the services being billed for by the provider on this claim.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(7)V9(2) COMP-3
Allowed Values:	Numeric. If there is a negative adjustment indicator (2,3,5), then must be < = 0.	
Comments and Special Considerations:	This field will contain the amount the recipient has paid or obligated against his Share of Cost (SOC) on this claim. E.g., The recipient SOC is $100.00. He has previously paid or obligated for $39.00. The amount in this field will be $61.00. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 505-F5, 'Patient Pay Amount'	
Revisions and History:	**Date**	**Description**

34.0 CO-INSURANCE AMOUNT

COBOL Name:	F35C-CO-INSURANCE-AMOUNT	
Location on Record:	**169-173**	
Definition:	Co-Insurance Amount identifies the co-insurance amount billed to Medi-Cal for Medicare services.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(7)V9(2) COMP-3
Allowed Values:	Numeric. If there is a negative Adjustment Indicator (2,3,5) then must be less than zero.	
Comments and Special Considerations:	For more information on FI, see FI Co-Insurance Amount, Appendix K. See Appendix A, F35C-CO-INSURANCE-AMOUNT-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 572-4U, 'Amount of Co-insurance'	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, Co-Insurance Amount	

35.0 OTHER COVERAGE AMOUNT

COBOL Name:	F35C-OTHER-COVERAGE-AMOUNT	
Location on Record:	**174-178**	
Definition:	Header Other Coverage Amount identifies amount paid by an insurance carrier or third party.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(7)V9(2) COMP-3
Allowed Values:	Numeric. If there is a negative adjustment indicator (2,3,5), then must be < = 0.	
Comments and Special Considerations:	See Detail Other Coverage Amount. For more information on FI, see HEADER OTHER COVERAGE AMOUNT, Appendix K. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 565-J4, 'Other Amount Paid'	
Revisions and History:	**Date**	**Description**

36.0 HDR MEDI-CAL AMOUNT BILLED

COBOL Name:	F35C-HDR-MEDI-CAL-AMT-BILLED	
Location on Record:	**179-183**	
Definition:	Total Medi-Cal Billed Amount indicates the amount Medi-Cal was billed by the provider for the claim.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(7)V9(2) COMP-3
Allowed Values:	Must be numeric, and can be zeroes or negative. If there is a negative Adjustment Indicator (2,3,5) then must be less than zero.	
Comments and Special Considerations:	May be less than the sum of the detail Medi-Cal Billed Amount fields. Usually zeros on Medicare/Medi-Cal crossover claims for EDS See Detail Medi-Cal Billed Amount for detail Medi-Cal Billed Amount information. See Appendix A, F35C-HDR-MEDI-CAL-AMT-BILLED-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 430-DU, 'Gross Amount Due'	
Revisions and History:	**Date**	**Description**

37.0 HDR TOTAL MEDI-CAL AMOUNT PAID

COBOL Name:	F35C-HDR-MEDI-CAL-AMOUNT-PAID	
Location on Record:	**184-188**	
Definition:	Total Medi-Cal Paid Amount identifies the amount Medi-Cal reimbursed the provider for the claim.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(7)V9(2) COMP-3
Allowed Values:	Must be numeric, and can be zeroes or negative. If there is a negative Adjustment Indicator (2,3,5) then must be less than zero.	
Comments and Special Considerations:	This field is the sum of the detail Medi-Cal Reimbursed Amount fields. May be less than the sum of the detail Medi-Cal Paid Amount fields on a claim. Usually zeros on Medicare/Medi-Cal crossover claims. See Medi-Cal Reimbursed Amount for Medi-Cal Reimbursed Amount information. See Detail Medi-Cal Paid Amount for detail Medi-Cal Paid Amount information. For more information on FI, see HDR Medi-Cal Amount Paid, Appendix K. See Appendix A, F35C-HDR-MEDI-CAL-AMOUNT-PAID-Edit for more information.	
Revisions and History:	**Date**	**Description**

38.0 MEDICARE DEDUCTION AMOUNT

COBOL Name:	F35C-MEDICARE-DEDUCTION-AMOUNT	
Location on Record:	**189-193**	
Definition:	Medicare Deduction Amount indicates the Medicare deductible amount billed to Medi-Cal for this service.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(7)V9(2) COMP-3
Allowed Values:	Numeric. If there is a negative adjustment indicator (2,3,5), then must be < = 0.	
Comments and Special Considerations:	For more information on FI, see Medicare Deduction Amount, Appendix K. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 231, 'COB Primary Payor Deductible'	
Revisions and History:	**Date**	**Description**

39.0 MEDICARE DEDUCTION CODE

COBOL Name:	F35C-MEDICARE-DEDUCTION-CODE	
Location on Record:	**194-194**	
Definition:	Medicare deduction Code identifies type of deductible amount reported in Medicare Deduction Amount for Medicare claims.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Must be alphanumeric, space, or low-values: A = Medicare Part A Eligible B = Medicare Part B Eligible C = Medicare Part A & B Eligible D = Medicare Part D Eligible E = Medicare Part A & Part D Eligible F = Medicare Part B & Part D Eligible G = Medicare Part A, Part B, Part D Eligible Space = Not Medicare Eligible	
Comments and Special Considerations:	For more information on FI, see Medicare Deduction Code, Appendix K.	
Revisions and History:	**Date**	**Description**
	6/7/2007	Updates from MMA Part D

40.0 FAMILY PLANNING CLAIM

COBOL Name:	F35C-FAMILY-PLANNING-CLAIM	
Location on Record:	**195-195**	
Definition:	Family Planning Indicator indicates family planning services were provided.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	1 Family Planning/Sterilization. 2 Family Planning/Other. Space Not a Family Planning claim.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

41.0 ADJUSTMENT INDICATOR

COBOL Name:	F35C-ADJUSTMENT-INDICATOR	
Location on Record:	**197-197**	
Definition:	Adjustment Indicator identifies the record as an adjustment.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Can be numeric or space. DHCS Adjustment Codes 1 Positive supplemental 2 Negative supplemental (negative only) 4 Positive side of void and reissue 3 Refund to Medi-Cal (negative only) 5 Negative side of void and reissue 6 Cash disposition (obsolete) Space Not an adjustment Note: With reference to County Organized Health System pharmacy claims reporting, Reversals are to be coded as '3'; adjustments are not permitted.	
Comments and Special Considerations:	The adjustments may be either positive or negative. For more information on FI, see FI Adjustment Indicator, Appendix K. See Appendix A, F35C-ADJUSTMENT-INDICATOR-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 205, 'Adjustment Type'	
Revisions & History :	**Date**	**Description**

42.0 DAYS STAY

COBOL Name:	F35C-DAYS-STAY	
Location on Record:	**198-199**	
Definition:	Days Stay indicates the number of days that the patient stayed in the hospital (Inpatient claims only).	
Format Description:	Data Type:	Packed
	Display Length:	3
	Storage Length:	2
	Picture Clause:	S9(03) COMP-3
Allowed Values:	Numeric, with days stay values of -1 through -60 and 1 through 60. This field will contain zeroes if the claim is only for ancillary services. This field can be negative if it is an adjustment record	
Comments and Special Considerations:	For more information on FI, see FI Days Stay, Appendix K. See Appendix A, F35C-DAYS-STAY-Edit for more information.	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, Days Stay	

43.0 ADJUSTMENT CCN

COBOL Name:	F35C-ADJUSTMENT-CCN	
Location on Record:	**200-206**	
Definition:	This field (Adjustment CCN) is the CCN of the original claim being adjusted.	
Format Description:	Data Type:	Packed
	Display Length:	13
	Storage Length:	7
	Picture Clause:	S9(13) COMP-3
Allowed Values:	Numeric	
Comments and Special Considerations:	This field is applicable only to Adjustment Claims and provides an audit trail of adjustment to adjusted claim. See Claim Control Number (a.k.a., Internal Control Number). For more information on FI, see FI Adjustment CCN, Appendix K. See Appendix A, F35C-ADJUSTMENT-CCN-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, The Adjustment CCN must be identical to the CCN of the original claim that is being reversed/voided.	
Revisions and History:	**Date**	**Description**

44.0 HEADER FROM DATE OF SERVICE

COBOL Name:	HDR-FROM-DATE-OF-SERVICE	
Location on Record:	**207-214**	
Definition:	Header From Date of Service identifies the earliest 'From Date Of Service' of the detail segments.	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(8)
Allowed Values:	CCYYMMDD	
Comments and Special Considerations:	This is the earliest date of service for the period of service being reported by the provider in this claim. See Detail From Date of Service for more information. FI information can be found in Appendix K, FI Header From Date of Service See Appendix A, F35C-HDR-FROM-DATE-OF-SERVICE-Edit to see edits. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 401-D1, 'Date of Service' Pharmacy Claims: Header from Date of Service must be included on all compound drug claims.	
Revisions and History:	**Date**	**Description**

45.0 HEADER TO DATE OF SERVICE

COBOL Name:	HDR-TO-DATE-OF-SERVICE	
Location on Record:	**215-222**	
Definition:	Header To Date of Service identifies the latest 'Detail To Date of Service' of the detail segments.	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)
Allowed Values:	CCYYMMDD	
Comments and Special Considerations:	See Appendix A, F35C-HDR-TO-DATE-OF-SERVICE-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 401-D1, 'Date of Service'	
Revisions and History:	**Date**	**Description**

46.0 HDR AID CATEGORY

COBOL Name:	F35C-AID-CATEGORY	
Location on Record:	**227-228**	
Definition:	Aid Category identifies which aid code the claim was paid under.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:	For more information on FI, see HDR Aid Category, Appendix K. See Appendix A, F35C-AID-CATEGORY-Edit for more information.	
Revisions and History:	**Date**	**Description**

47.0 FFP INDICATOR

COBOL Name:	F35C-FFP-IND	
Location on Record:	**229-229**	
Definition:	FFP Indicator identifies what FFP (Federal Financial Participation) rate was used for payment.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Space = Unknown	
Comments and Special Considerations:	This field is not used and will always be space-filled. For more information on FI, see FI FFP Indicator, Appendix K.	
Revisions and History:	**Date**	**Description**
	1/11/02	Field is not used comment. Ejof
	For the history of this data element, see Appendix G, FFP Indicator	

48.0 CROSSOVER STATUS CODE

COBOL Name:	F35C-CROSSOVER-STATUS-CODE	
Location on Record:	**230-230**	
Definition:	Crossover Status Code defines whether or not Medicare covers a recipient.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	1 = Medicare Part A Eligible 2 = Medicare Part B Eligible 3 = Medicare Part A & B Eligible 4 = Medicare Part D Eligible 5 = Medicare Part A & Part D Eligible 6 = Medicare Part B & Part D Eligible 7 = Medicare Part A, Part B, Part D Eligible Space = Not Medicare Eligible	
Comments and Special Considerations:	For more information on FI, see FI Crossover Status Code, Appendix K.	

Revisions and History:	**Date**	**Description**
	6/7/2007	Updates from MMA Part D

49.0 OTHER COVERAGE INDICATOR

COBOL Name:	F35C-OTHER-COVERAGE-INDICATOR	
Location on Record:	**231-231**	
Definition:	Other Coverage Indicator indicates that there was a non-Medicare other health insurance for the claim.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Space = No other health insurance 1 = Has other health insurance	
Comments and Special Considerations:	See Other Health Care (OHC) Coverage Code for the valid Other Health Care Coverage code values. For more information on FI, see OTHER COVERAGE INDICATOR, Appendix K. See Appendix A, F35C-OTHER-COVERAGE-INDICATOR-Edit for more information.	
Revisions and History:	**Date**	**Description**

50.0 BIRTHDATE

COBOL Name:	F35C-BIRTHDATE	
Location on Record:	**232-239**	
Definition:	Birth Date identifies the Medi-Cal recipient's date of birth.	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)
Allowed Values:	CCYYMMDD, where: CC = Century YY = Year MM = Month DD = Day	
Comments and Special Considerations:	See Appendix A, F35C-BIRTHDATE-Edit for more information. For more information on FI, see BIRTH DATE, Appendix K. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 304-C4, 'Member DOB'	
Revisions and History:	**Date**	**Description**

51.0 CCS GHPP INDICATOR

COBOL Name:	F35C-CCS-GHPP-INDICATOR	
Location on Record:	**246-246**	
Definition:	CCS/GHPP Indicator indicates service authorized by the California Children's Services (CCS) or Genetically Handicapped Persons Program (GHPP).	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Space or 0 = Not CCS/GHPP service 1 = CCS/GHPP service	
Comments and Special Considerations:	To determine which program applies to the claim, the age at the date of service must be calculated. CCS is for those under age 21 years, and GHPP is for those 21 years of Age and above. For information on CCS, see http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx and for GHPP, see http://www.dhcs.ca.gov/services/ghpp/Pages/default.aspx. See Appendix A, F35C-CCS-GHPP-INDICATOR-Edit for more information.	
Revisions and History:	**Date**	**Description**

52.0 PROVIDER NAME

COBOL Name:	F35C-PROVIDER-NAME	
Location on Record:	**247-274**	
Definition:	Provider Name identifies the name of the billing provider.	
Format Description:	Data Type:	Character
	Display Length:	28
	Storage Length:	28
	Picture Clause:	X(28)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:	Contains the name of the facility, clinic, ambulance company, etc. Left justified, consisting of any or all of the following: LAST NAME space FIRST NAME space INITIAL or the company's name. For more information on FI, see FI Provider Name, Appendix K. See Appendix A, F35C-PROVIDER-NAME-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 833-5P, 'Pharmacy Name'	
Revisions and History:	**Date**	**Description**

53.0 MINOR CONSENT SERVICE

COBOL Name:	F35C-MINOR-CONSENT-SERVICE	
Location on Record:	**275-276**	
Definition:	Minor Consent Service Code identifies the recipient as a minor consent eligible and to identify the minor consent services needed.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Value Definition Blank = Not applicable for minor consent services 05 = Services related to Mental Health, Sexual Assault, Drug and/or Alcohol Abuse, Pregnancy or Family Planning and Venereal Disease 07 = Services related to Drug or Alcohol Abuse, Pregnancy or Family Planning and Venereal Disease 08 = Services related to Pregnancy or Family Planning Venereal Disease	
Comments and Special Considerations:	This is also known as the sensitive service code. Before the minor consent aid codes were implemented, the county controlled the minor consent values on MEDS. Now the counties cannot change them unless they contact Medi-Cal Eligibility Branch. For more information on FI, see FI Minor Consent Service, Appendix K.	
Revisions and History:	**Date**	**Description**
	6/18/2007	Modified from the current EDS 35 Paid Claims File

54.0 RESTRICTED SERVICE

COBOL Name:	F35C-RESTRICTED-SERVICE	
Location on Record:	**277-278**	
Definition:	Restricted Service Code identifies if the recipient has been placed on or removed from restricted status.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	01 Drug Restriction 05 Restricted scheduled drugs 11 Restricted M.D. Visits 12 Restricted M.D. Visits and drugs 14 Restricted to Primary M.D. 15 Restricted to Primary M.D./drugs 20 Prior authorization required for Dental visits 21 Prior authorization required for Dental visits and drugs 22 Prior authorization required for Physician visits and Dental visits 23 Prior authorization required for Physician visits, Dental visits, and drugs 24 Recipient is restricted to primary Physician with prior authorization 60 For claims payment, BIC Id number and issue date required 70 CMSP OCCS Emergency Services Only 90 Hospice Services Only 91 Hospice Services Only 92 Hospice Services Only 93 Hospice Services plus other restriction 95 Transfer of Assets - no LTC Scope 00 Restriction Lifted	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	6/15/2007	Updated to show values in MEDS
	For the history of this data element, see Appendix G, Restricted Service	

55.0 FI CLAIM TYPE

COBOL Name:	F35C-FI-CLAIM-TYPE	
Location on Record:	**279-280**	
Definition:	FI Claim Type identifies the type of claim used for this billing and the type of edits that were applicable.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	01 = Pharmacy 02 = Long Term Care 03 = Hospital Inpatient 04 = Outpatient 05 = Physician 06 = Crossover 07 = Vision 09 = TAR	
Comments and Special Considerations:	Different claim types have different data elements and edits that are applicable to the billing. This code identifies which claim was billed with special categories for vision and hospital outpatient/ inpatient due to special edits. Please refer to claim for more information. For more information on FI, see FI CLAIM TYPE, Appendix K. See Appendix A, F35C-FI-CLAIM-TYPE-Edit for more information.	
Revisions and History:	**Date**	**Description**

56.0 HEALTH PLAN CODE

COBOL Name:	F35C-HEALTH-PLAN-CODE	
Location on Record:	**281-283**	
Definition:	Health Plan Care Code (also known as Prepaid Health Plan Code) identifies the prepaid health plan that the recipient is enrolled in	
Format Description:	Data Type:	Character
	Display Length:	3
	Storage Length:	3
	Picture Clause:	X(03)
Allowed Values:	000 No PHP/HCP 001-199 Prepaid Health Plans (PHP) (May include Dental) 200-299 Special Projects (Capitated) 300-399 Prepaid Health Plans (PHP) 400-499 Dental Plans 500-550 County Operated Health Systems (COHS) 502 Santa Barbara 503 San Mateo 504 Solano 505 Santa Cruz 506 Orange 507 Napa 508 Monterey 509 Yolo 510 Marin 551-559 Reserved 560-599 Unassigned 600 Not active 601 Special project: Psychiatric (Capitated) 603-639 Special projects: Medical (Non-capitated) 640-660 Fee-For-Service/Managed Care Network (FFS/MCN) 680-699 Dental Only (Capitated)Exclusively for Adult Day Health Care, but none are active (3/00) 800-899 Primary Care Case Management (PCCM) (May include dental) 900-998 Primary Care Case Management (PCCM) (May include dental) 999 Bene active in other than medical HCP	
Comments and Special Considerations:	For more information on FI, see HEALTH PLAN CODE, Appendix K. See Appendix A, F35C-HEALTH-PLAN-CODE-Edit for more information.	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, RECIPIENT PREPAID HEALTH PLANS(PHP) CODE.	

57.0 FI PROVIDER TYPE

COBOL Name:	F35C-FI-PROVIDER-TYPE.	
Location on Record:	**284-286**	
Definition:	FI Provider Type Code identifies the classification of the provider rendering health and medical services using the newer 3-digit coding.	
Format Description:	Data Type:	Character
	Display Length:	3
	Storage Length:	3
	Picture Clause:	X(03)
Allowed Values:	Digit (0-9) Please refer to Appendix R, PROVIDER TYPE CODES for a list of the provider type codes.	
Comments and Special Considerations:	As of the March 2000 file, there are no COHS or FI providers that start with a '1'. So as of now both sets of fields have values in them. See Comparison Of Provider Type and Category Of Service Codes, Appendix E. for a list of the provider type codes cross-referenced to Category of Service codes. For more information on FI, see FI PROVIDER TYPE CODE, Appendix K. See Appendix A, F35C-FI-PROVIDER-TYPE-Edit for more information.	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, FI Provider Type.	

58.0 CATEGORY OF SERVICE

COBOL Name:	F35C-CATEGORY-OF-SERVICE	
Location on Record:	**287-289**	
Definition:	Category of Service identifies the category of service the service (procedure) code falls into and that the provider is qualified to render (using the newer 3-digit coding).	
Format Description:	Data Type:	Character
	Display Length:	3
	Storage Length:	3
	Picture Clause:	X(03)
Allowed Values:	Digits (0-9) Please refer to EDS Category Of Service (COS), Appendix J for a list of the EDS category of service codes.	
Comments and Special Considerations:	For more information on FI, see FI Category of Service, Appendix K. See Appendix A, F35C-CATEGORY-OF-SERVICE-Edit for more information.	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, Category of Service	

59.0 PRIMARY DIAGNOSIS CODE

COBOL Name:	F35C-PRIMARY-DIAGNOSIS	
Location on Record:	**290-296**	
Definition:	Primary Diagnosis Code identifies the diagnosis code for the principal condition requiring medical attention.	
Format Description:	Data Type:	Character
	Display Length:	7
	Storage Length:	7
	Picture Clause:	X(07)
Allowed Values:	Alphanumeric or spaces.	
Comments and Special Considerations:	Please refer to International Classification of Diseases-Clinical Modifications, Revision 9 (ICD-9-CM) for ICD-9 codes. For Short/Doyle Mental Health and Alcohol and Drug treatment claims, refer to Diagnostic and Statistical Manual of Mental Disorders (DSM) IV diagnostic codes as defined by American Psychiatric Diagnostic Service Manual Fourth Edition. The ICD-9 codes can be 3 to 5 characters. The 3-digit version of the code is the most general description. The 4th and 5th character offer a more detailed description. Pharmacy, laboratory, assistant surgeons, and anesthesiologist claims may not have diagnosis codes because it is not required. Therefore, it is possible to find all zeroes or spaces in the diagnosis code field. See Secondary Diagnosis Code (ICD) for more Information on diagnosis codes. See Appendix A, F35C-PRIMARY-DIAGNOSIS-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 424-DO, 'Diagnosis Code'	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, Primary Diagnosis Code.	

60.0 SECONDARY DIAGNOSIS CODE

COBOL Name:	F35C-SECONDARY-DIAGNOSIS	
Location on Record:	**297-303**	
Definition:	Secondary Diagnosis Code identifies patient's secondary diagnosis, which requires supplementary medical treatment.	
Format Description:	Data Type:	Character
	Display Length:	7
	Storage Length:	7
	Picture Clause:	X(07)
Allowed Values:	Alphanumeric or spaces.	
Comments and Special Considerations:	These codes are to be ICD-9-CM diagnosis codes, which can be 3 to 5 characters. See Primary Diagnosis Code (ICD) for more information on diagnosis codes. For more information on FI, see FI Secondary Diagnosis, Appendix K. See Appendix A, F35C-SECONDARY-DIAGNOSIS-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 424-DO, 'Diagnosis Code'	
Revisions and History:	**Date**	**Description**

61.0 EMERGENCY INDICATOR

COBOL Name:	F35C-EMERGENCY-IND	
Location on Record:	**304-304**	
Definition:	Claim Emergency Indicator indicates whether the service was performed in an emergency situation.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Y = Emergency. N = Non-emergency. 0 = Non-emergency. Space = Non-emergency	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

62.0 ADMIT TYPE

COBOL Name:	F35C-ADMIT-TYPE	
Location on Record:	**305-305**	
Definition:	Inpatient Admission Necessity/Type Code indicates the necessity for admission to an inpatient hospital.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	When Form UB-92 (Claim Form Indicator = 'U') 1 = Emergency (transfer if Admit Source = 4, 5, or 6) 2 = Urgent 3 = Elective (transfer if Admit Source = 4, 5, or 6) 4 = Newborn (can be either a transfer or not since Admit Source is always a space for newborns) 9 = Information not available When not Form UB-92 (Claim Form Indicator not = 'U') 1 = Emergency 2 = Elective 3 = Delivery* 4 = Emergency (transfer) 5 = Elective (transfer) 6 = Delivery (transfer)* Encounter claims 1 = Emergency 2 = Elective 3 = Newborn 4 = Delivery	
Comments and Special Considerations:	See Claim Form Indicator for Claim Form Indicator information. See Admit Source for the Admit source values. For more information on FI, see ADMIT TYPE, Appendix K. See Appendix A, F35C-ADMIT-TYPE-Edit for more information.	
Revisions and History:	**Date**	**Description**

63.0 PATIENT STATUS CODE

COBOL Name:	F35C-PATIENT-STATUS	
Location on Record:	**306-307**	
Definition:	FI Discharge/Patient Status Code indicates the status of the patient in Long Term Care or in an inpatient hospital on the through (TO) date of service on the claim.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	<u>UB92 valid values follow for hospital inpatient claims when the Claim Form Indicator is set to 'U'</u>: 01 = Discharged to home or self care 02 = Discharged/transferred to another acute hospital 03 = Discharged/transferred to a SNF 04 = Discharged/transferred to an ICF 20 = Expired 30 = Still patient or expected to return 31 = Admitted (First Interim Bill) <u>Valid values follow for Long Term Care claims</u>: 00 = Still under care 01 = Admitted (interim bill) 02 = Expired (Deceased) 03 = Discharged to acute hospital 04 = Discharged to home 05 = Discharged to another Long Term Care facility 06 = Leave of absence to acute hospital (bed hold) 07 = Leave of absence to home 08 = Leave of absence to acute hospital/discharged 09 = Leave of absence to home/discharged 10 = Admitted/expired 11 = Admitted/discharged to acute hospital 12 = Admitted/discharged to home 13 = Admitted/discharged to other Long Term Care facility <u>Encounter Outpatient Patient Status Codes</u> AA = Referred to Another Physician AB = Return to Referring Physician AC = Return if Needed – PRN AD = Telephone Follow Up BA = Referred to CHDP BB = Referred to CCS BD = Referred to WIC Services BC = Referred to CPSP Services	

<table>
<tr><td>Comments and Special Considerations:</td><td colspan="2">See Discharge/Patient Status Code for DHCS discharge codes.

See Claim Form Indicator for DHCS's claim Form Indicator.

For more information on FI, see DHCS DISCHARGE/PATIENT STATUS CODE, Appendix K.

See Appendix A, F35C-PATIENT-STATUS-Edit for more information.</td></tr>
<tr><td rowspan="4">Revisions and History:</td><td>Date</td><td>Description</td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">For the history of this data element, see Appendix G, History of Discharge/Patient Status Code .</td></tr>
</table>

64.0 PRIMARY SURGERY CODE

COBOL Name:	F35C-PRIMARY-SURGERY-CODE	
Location on Record:	**308-314**	
Definition:	Inpatient Primary Surgery Code identifies the principal surgical procedure performed in an inpatient hospital, if applicable.	
Format Description:	Data Type:	Character
	Display Length:	7
	Storage Length:	7
	Picture Clause:	X(07)
Allowed Values:	Alphanumeric. After September 22, 2004, primary surgery code will contain only ICD-9 volume 3 procedure codes. Before September 22, 2004, please refer to HCPCS (Health Care Financing Administration Common procedure Coding System), CPT-4s (Current Procedure Terminology, Fourth Edition), ICD-9 Volume 3 for procedure codes.	
Comments and Special Considerations:	See INPATIENT SECONDARY SURGERY CODE for the secondary surgery codes. See Appendix A, F35C-PRIMARY-SURGERY-CODE-Edit for more information.	
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

65.0 PRIMARY SURGERY CODE PROCVAL INDICATOR

COBOL Name:	F35C-PRI-SURG-CODE-PROCVAL-IND	
Location on Record:	**315-316**	
Definition:	For future use.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

66.0 SECONDARY SURGERY CODE

COBOL Name:	F35C-SECONDARY-SURGERY-CODE	
Location on Record:	**317-323**	
Definition:	Inpatient Secondary Surgery Code identifies the secondary surgical procedure performed in an inpatient hospital, if applicable.	
Format Description:	Data Type:	Character
	Display Length:	7
	Storage Length:	7
	Picture Clause:	X(07)
Allowed Values:	Alphanumeric. After September 22, 2004, the secondary surgery code will contain ICD-9 volume 3 procedure codes. Before September 22, 2004, please refer to HCPCS (Health Care Financing Administration Common procedure Coding System), CPT-4s (Current Procedure Terminology, Fourth Edition), ICD-9 Volume 3 procedure codes for codes.	
Comments and Special Considerations:	See Inpatient Primary Surgery Code for the primary surgery codes. See Appendix A, F35C-SECONDARY-SURGERY-CODE-Edit for more information.	
Revisions and History:	**Date**	**Description**

67.0 SECONDARY SURGERY CODE PROCVAL INDICATOR

COBOL Name:	F35C-SEC-SURG-CODE-PROCVAL-IND	
Location on Record:	**324-325**	
Definition:	For future use.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

68.0 SURGERY DATE

COBOL Name:	F35C-SURGERY-DATE	
Location on Record:	**326-333**	
Definition:	Inpatient Surgery Date identifies the date on which the principle surgery was performed in an inpatient hospital, if applicable.	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)
Allowed Values:	CCYYMMDD where: CC = Century YY = Year MM = Month DD = Day	
Comments and Special Considerations:	See Appendix A, F35C-SURGERY-DATE-Edit for more information.	
Revisions and History:	**Date**	**Description**

69.0 CLAIM FORM INDICATOR

COBOL Name:	F35C-CLAIM-FORM-INDICATOR	
Location on Record:	**334-334**	
Definition:	Claim Form Indicator identifies if the claim form used to input the claim is a UB-92 or a HCFA - 1500 form.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	U = UB-92 form input. H = HCFA-1500 form input. N = NCPDP Space = Neither UB-92, NCPDP, nor HCFA-1500 form input.	
Comments and Special Considerations:	This field is required to determine which kind of Admit Source is listed for inpatient claims that come in on the UB-92 form. This field also is used to inform when the HCFA-1500 form is used.	
Revisions and History:	**Date**	**Description**

70.0 ADMIT SOURCE

COBOL Name:	F35C-ADMIT-SOURCE	
Location on Record:	**340-340**	
Definition:	Admit Source identifies the reason a patient was admitted to a hospital.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Space = Newborn or not a transfer or not a UB-92 Claim form. 1 = Physician referral 2 = Clinic referral 3 = HMO referral 4 = Transfer from a hospital 5 = Transfer from a skilled nursing facility 6 = Transfer from another health care facility 7 = Emergency Room 8 = Court/Law enforcement 9 = Information not available	
Comments and Special Considerations:	The Admit Source Code is needed to determine the meaning of the values in the Admission Necessity Code if the Claim Form Indicator is 'U'. This field is always a space when the Claim Form Indicator is not 'U'. See Admit Type for the Admission Necessity Code information. See Appendix A, F35C-ADMIT-SOURCEF35C-ADMIT-SOURCE-Edit for more information.	
Revisions and History:	**Date**	**Description**

71.0 RELATED CAUSES CODES

COBOL Name:	F35C-RELATED-CAUSES-CODES	
Location on Record:	**341-346**	
Definition:	Related Causes Information identifies an accompanying cause of an illness, injury, or an accident.	
Format Description:	Data Type:	Character
	Display Length:	6
	Storage Length:	6
	Picture Clause:	X(02) occurs 3 times
Allowed Values:	Alphanumeric. Up to 3 codes with 2 characters per code. At least 1 code is required when the condition being reported is accident or employment related. <u>Code Definition</u> AA = Auto Accident AB = Abuse AP = Another Party Responsible EM = Employment OA = Other Accident	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

72.0 ADMITTING FACILITY PROVIDER NUMBER

COBOL Name:	F35C-ADMITG-FACILITY-PROV-NUM	
Location on Record:	**347-356**	
Definition:	The admitting facility provider number is the number code of the admitting facility (e.g., hospital, LTC, SNF, etc.)	
Format Description:	Data Type:	Character
	Display Length:	10
	Storage Length:	10
	Picture Clause:	X(10)
Allowed Values:	Alphanumeric.	
Comments and Special Considerations:	This field can contain NPI or other provider numbers such as the Medi-Cal provider number. Provider numbers are assigned primarily to facilitate billing activities, so a 'provider' may have multiple ID numbers. For example, a hospital might have an inpatient number, outpatient number and a long term care number. There is some standardization, such as long-term care numbers beginning LTC, but there are many exceptions. The individual physician numbers have a feature which distinguishes how many offices s/he has: Right most position = 0 = the physician works for a group provider Right most position = 1 = one office Right most position = 2 = two offices, etc. See Appendix Q, Provider Naming/Number System for the list of provider naming and number acronyms. Information related to FI can be found in FI Provider Number See Appendix A, F35C-ADMITG-FACILITY-PROV-NUM-Edit for more information.	

Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

73.0 CONTRACT INDICATOR

COBOL Name:	F35C-CONTRACT-IND	
Location on Record:	**357**	
Definition:	The Contract Indicator field shows whether a provider has a contracted provider number or a non-contracted provider number.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	'Y' = Yes 'N', '0', or Space = No	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

74.0 RECORD ID

COBOL Name:	F35C-RECORD-ID-NUMBER	
Location on Record:	**456-463**	
Definition:	Record Identification Number uniquely identifies any paid claim. Used for external users to help identify records that may be in error and link compound segments. **Note:** the fiscal intermediaries and other organizations that submit claims and encounter data to the State do not populate the Record Identification Number (RIN). The RIN is populated by the State for files that are sent to external users who require the RIN field	
Format Description:	Data Type:	Packed
	Display Length:	15
	Storage Length:	8
	Picture Clause:	S9(15) COMP-3
Allowed Values:	Numeric; will always be a positive value; must be in form YYMMDD######### (YYMMDD is the date the monthly file is processed. #'s represent a unique sequential number assigned to each claim for that file.)	
Comments and Special Considerations:	The purpose of the Record Identification Number (RIN) is to enable external data users and DHCS to locate records with which there may be a problem. External users also requested the RIN for their systems so they can link the compound drug segments to the header. Previously, the ICN number as well as other fields that are used to identify claims proved unreliable for this purpose.	
Revisions and History:	**Date**	**Description**

75.0 EDIT FLAG

COBOL Name:	F35C-EDIT-FLAG	
Location on Record:	**464-464**	
Definition:	Internal status code for claim	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Valid values are: Space - Initial A - Accept B – Reject BPST C – Reject CIN Tag D – Reject Duplicate R – Reject Drop Edit S – Reject Suspense	
Comments and Special Considerations:	Populated only by CA DHCS for use in MIS/DSS.	
Revisions and History:	**Date**	**Description**

76.0 EDIT FLAG 2

COBOL Name:	F35C-EDIT-FLAG-2	
Location on Record:	**465-465**	
Definition:	Internal status code for claim	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:		
Comments and Special Considerations:	Populated only by CA DHCS for use in MIS/DSS.	
Revisions and History:	**Date**	**Description**

77.0 EDIT ERROR CODE

COBOL Name:	F35C-EDIT-ERROR-CODE	
Location on Record:	**466-468**	
Definition:	Internal status code for claim	
Format Description:	Data Type:	Character
	Display Length:	3
	Storage Length:	3
	Picture Clause:	X(03)
Allowed Values:		
Comments and Special Considerations:	Populated only by CA DHCS for use in MIS/DSS.	
Revisions and History:	**Date**	**Description**

78.0 RECORD SOURCE CODE

COBOL Name:	F35C-RECORD-SOURCE-CODE	
Location on Record:	**469-470**	
Definition:	Internal status code for claim	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:		
Comments and Special Considerations:	Populated only by CA DHCS for use in MIS/DSS.	
Revisions and History:	**Date**	**Description**

79.0 SEGMENT TYPE M

COBOL Name:	F35C-SEGMENT-TYPE-M	
Location in Main Type Segment:	**001-001**	
Definition:	Segment Type identifies whether the segment is a main segment or compound drug segment.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Value must be 'M' for Main Segment Type.	
Comments and Special Considerations:	A compound drug claim record normally has one, and only one, main type segment as the first detail segment, followed by 0-40 compound drug segments. The number of compound drug segments depends upon the compound drug number of ingredients. The segment count in the claim header is thus normally one more than the compound drug number of ingredients. A compound drug claim record can have a segment count of zero, with no detail segments. (Prior to the time compound drug ingredients were reported, a drug claim can have multiple compound drugs reported on a claim. In that case, the record will have no compound drug segments.)	
Revisions and History:	**Date**	**Description**

80.0 CCN LINE NUMBER

COBOL Name:	F35C-CCN-LINE-NUMBER	
Location in Main Type Segment:	**002-003**	
Definition:	The last two characters of the Claim Control Number (CCN) are the claim line number and they are unique for each service.	
Format Description:	Data Type:	Numeric
	Display Length:	2
	Storage Length:	2
	Picture Clause:	9(02)
Allowed Values:	Numeric	
Comments and Special Considerations:	For more information on FI, see CCN LINE NUMBER, Appendix K.	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, CCN Line Number	

81.0 DETAIL MEDI-CAL AMOUNT BILLED

COBOL Name:	F35C-DET-MEDI-CAL-AMT-BILLED	
Location in Main Type Segment:	**004-008**	
Definition:	Detail Medi-Cal Billed Amount identifies the amount billed for this service.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(07)V9(2) COMP–3
Allowed Values:	Numeric. If there is a negative adjustment indicator (2,3,5), then must be < = 0. **Note:** Negative only for Adjustment claim.	
Comments and Special Considerations:	The amount provider billed Medi-Cal for the service rendered or product provided. See HDR MEDI-CAL AMOUNT BILLED for total Medi-Cal Billed information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 430-DU, 'Gross Amount Due'	
Revisions and History:	**Date**	**Description**

82.0 DETAIL MEDI-CAL ALLOWED AMOUNT

COBOL Name:	F35C-DET-MEDI-CAL-ALLOWED-AMT	
Location in Main Type Segment:	**009-013**	
Definition:	Detail Medi-Cal Allowed Amount (Previously named 'Detail Medi-Cal Amount Paid) identifies the maximum amount payable for this service by Medi-Cal.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(07)V9(2) COMP–3
Allowed Values:	Numeric. If there is a negative adjustment indicator (2,3,5), then must be < = 0.	
Comments and Special Considerations:	Previously named 'DETAIL MEDI-CAL AMOUNT PAID'. This field is actually the allowed amount and generally represents what Medi-Cal would pay before any adjustments are made for patient liability or other reasons. This is not necessarily the amount paid but the amount payable before coinsurance, liability, cutbacks, etc. are applied. See HDR Medi-Cal Amount Paid for total Medi-Cal Paid Amount information. For more information on FI, see DETAIL MEDI-CAL ALLOWED AMOUNT, Appendix K.	
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

83.0 MEDI-CAL REIMBURSED AMOUNT

COBOL Name:	F35C-MEDI-CAL-REIMBURSE-AMOUNT	
Location in Main Type Segment:	**014-018**	
Definition:	Medi-Cal Reimbursed Amount identifies the actual amount reimbursed for this detail line procedure.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(07)V9(2) COMP–3
Allowed Values:	Numeric. If there is a negative adjustment indicator (2,3,5), then must be < = 0.	
Comments and Special Considerations:	This amount is the amount paid after Third Party and other deductions are made to the allowed amount. If there are no deductions, this field would contain the same value as the Detail Medi-Cal Paid Amount field. However, if the Medi-Cal Detail Paid Amount less deductions is greater than the Detail Medi-Cal Billed Amount, then this field would be set to the value in the Detail Medi-Cal Billed Amount. See DETAIL MEDI-CAL PAID AMOUNT for more information on the detail Medi-Cal Paid/Allowed amount field. For more information on FI, see FI Medi-Cal Reimbursed Amount, Appendix K. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 281, 'Net Amount Due'	
Revisions and History:	**Date**	**Description**

84.0 MEDICARE AMOUNT BILLED

COBOL Name:	F35C-MEDICARE-AMOUNT-BILLED	
Location in Main Type Segment:	**019-023**	
Definition:	Medicare Amount Billed identifies amount billed to Medicare.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(07)V9(2) COMP–3
Allowed Values:	Numeric, can be zeros or negative.	
Comments and Special Considerations:	It is zeros on non-Medicare claims.	
Revisions and History:	**Date**	**Description**

85.0 MEDICARE AMOUNT PAID

COBOL Name:	F35C-MEDICARE-AMOUNT-PAID	
Location in Main Type Segment:	**024-028**	
Definition:	Medicare Paid Amount identifies amount paid by Medicare.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(07)V9(2) COMP–3
Allowed Values:	Numeric, can be zero or negative.	
Comments and Special Considerations:	It is zeros on non-Medicare claims.	
Revisions and History:	**Date**	**Description**

86.0 DETAIL FROM DATE OF SERVICE

COBOL Name:	F53B-DET-FROM-DATE-OF-SERVICE	
Location in Main Type Segment:	**029-036**	
Definition:	Detail From Date of Service identifies the start date of the service on this detail.	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)
Allowed Values:	CCYYMMDD, where: CC = Century YY = Year MM = Month DD = Day	
Comments and Special Considerations:	This date can be whenever services were rendered, regardless of month of payment. For example, month of payment could be 20010401 and the claim month of service could be 20010101. See Header From Date Of Service (DOS), for Date of Service information. See Appendix A, F35C-DET-FROM-DATE-OF-SERVICE-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 401-D1, 'Date of Service'	
Revisions and History:	**Date**	**Description**

87.0 DETAIL TO DATE OF SERVICE

COBOL Name:	F53B-DET-TO-DATE-OF-SERVICE	
Location in Main Type Segment:	**037-044**	
Definition:	Detail To Date of Service identifies the end date of the service on this detail.	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)
Allowed Values:	CCYYMMDD, where: CC = Century YY = Year MM = Month DD = Day	
Comments and Special Considerations:	See Header To Date Of Service (DOS)) for To Date of Service information. See Appendix A, F35C-DET-TO-DATE-OF-SERVICE-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 401-D1, 'Date of Service'	
Revisions and History:	**Date**	**Description**

88.0 PRIMARY CARE CASE MANAGEMENT (PCCM) INDICATOR

COBOL Name:	F35C-PCCM-IND	
Location in Main Type Segment:	**045-045**	
Definition:	Primary Care Case Management Indicator identifies if this is a Primary Care Case Management record.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Y = PCCM N = Not PCCM 0 (zero) = Not PCCM Space = Not PCCM	
Comments and Special Considerations:	See COPAY AMOUNT for details on Co-pay Amount and information See Copay Indicator for details on the Co-pay Indicator.	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, PCCM Indicator.	

89.0 OTHER HEALTH COVERAGE (OHC) CODE

COBOL Name:	F35C-OHC-CODE	
Location in Main Type Segment:	**046-046**	
Definition:	Other Health Care Coverage Code identifies the Other Health Care (OHC) circumstances for each service rendered.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	These are the current values which subject to change: A Any Carrier (includes multiple coverage) C CHAMPUS Prime HMO D Medicare Part D F Medicare RISK HMO K Kaiser L Dental only policies P PHP/HMOs and EPO (Exclusive Provider Option) not otherwise specified V Any carrier other than the above, includes multiple coverage 9 Healthy Family Program (would be a K or P if the child was not enrolled in HF. Started 7/1/98.) Space No Coverage N No Coverage O Override - Used to remove cost avoidance OHC codes posted by DHCS Recovery (OHC-Source of H, R, or T); changes OHC to A or N.	
Comments and Special Considerations:	NOTE: Numeric '0' (ZERO) and '1' (one) are invalid values for OHC. For more information on FI, see FI OHC Code, Appendix K. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 308-C8, 'Other Coverage Code'	
Revisions and History:	**Date**	**Description**
	6/7/2007	MMA Part D changes
	For the history of this data element, see Appendix G, OHC Code.	

90.0 EPSDT SERVICE INDICATOR

COBOL Name:	F35C-EPSDT-SERVICE-IND	
Location in Main Type Segment:	**047-047**	
Definition:	EPSDT Service Indicator identifies the kind of service for Early Periodic Screening, Diagnosis and Treatment (EPSDT) claims.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Z - For HCPCS codes Z5800-Z5999 and SMA code 00010 (Rural Health and FQHC) E - For any other EPSDT service as was determined by the TAR number. Space - that it is not an EPSDT service	
Comments and Special Considerations:	These are Medi-Cal benefits for those aged less than 21 years that are paid even if they are not Medi-Cal benefits and even if some other kind of edit would normally have prevented payment. These include EPSDT supplemental services but are not limited to supplemental services. For more information on FI, see FI EPSDT Service Indicator, Appendix K.	
Revisions and History:	**Date**	**Description**

91.0 MEDI-CAL INTERMEDIARY OPERATIONS (MIO) PLACE OF SERVICE (POS)

COBOL Name:	F35C-MIO-POS	
Location in Main Type Segment:	**048-048**	
Definition:	DHCS Place of Service identifies where service was rendered.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)

Allowed Values:

DHCS POS	HCFA-1500	Not HCFA-1500
0 = Emergency Room		23 B
1 = Inpatient Hospital		21 3
2 = Outpatient Hospital		22 5
3 = Nursing Facility, Level A/B		31, 32, 91, 96 4, C, F, M, (Y on drug Claim only)
4 = Home		12 2
5 = Office, Lab, Clinic		11, 24, 25, 53, 1, 6, 8, 9, A 65, 71, 72, 81
6 = ICF-DD		54, 92, 93 G, H, I
7 = Other		41, 42, 55, 62, 7, J, K, 99
8 = Transitional		97 N Inpatient

Comments and Special Considerations:

EPSDT claims have low-values in this field.

See Appendix A, F35C-MIO-POS-Edit for more information.

Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 307-C7, 'Place of Service'

Revisions and History:

Date	Description

For the history of this data element, see Appendix G, DHS Place of Service

92.0 TAR CONTROL NUMBER

COBOL Name:	F35C-TAR-CONTROL-NUMBER	
Location in Main Type Segment:	**049-059**	
Definition:	TAR Control Number identifies the Treatment Authorization Control number assigned to pre-authorize this service.	
Format Description:	Data Type:	Character
	Display Length:	11
	Storage Length:	11
	Picture Clause:	X(11)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:	For more information on FI, see FI TAR Control Number, Appendix K. See Appendix A, F35C-TAR-CONTROL-NUMBER-Edit for more information.	
Revisions and History:	**Date**	**Description**

93.0 DRUG PROCEDURE AREA

COBOL Name:	F35C-DRUG-PROCEDURE-AREA	
Location in Main Type Segment:	**060-113**	
Definition:	This area is for reporting information on a drug or medical supply with a UPN number, NDC code or state Medi-Cal drug code. Information on a drug with a HCPCS code would be reported in the Other Procedure Area.	
Format Description:	Data Type:	Varies.
	Display Length:	54
	Storage Length:	54
	Picture Clause:	
Allowed Values:		
Comments and Special Considerations:	See Appendix A, F35C-DRUG-PROCEDURE-AREA-Edit for more information.	
Revisions and History:	**Date**	**Description**

93.1 DRUG PRODUCT ID QUALIFIER

COBOL Name:	F35C-DRUG-PRODUCT-ID-QUALIFIER	
Location in Main Type Segment:	**060-061**	
Definition:	Drug Product ID Qualifier identifies the type of code used in data element Drug Product ID	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Alphanumeric 03 - National Drug Code (NDC) N4 - National Drug Code (NDC)	
Comments and Special Considerations:	Code qualifying the value in 'Product/ Service ID' (NCPDP 5.3 field number 436-E1). The following are the possible values for this field, as detailed in the NCPDP Data Dictionary 5.1. However, the only values Medi-Cal plans to use at this time are 03, National Drug Code (NDC) and N4 (NDC): Space Not Specified 00 Not Specified 01 Universal Product Code (UPC) 02 Health Related Item (HRI) 03 National Drug Code (NDC) 04 Universal Product Number (UPN) 05 Department of Defense (DOD) 06 Drug Use Review/ Professional Pharmacy Service (DUR/PPS) 07 Common Procedure Terminology (CPT4) 08 Common Procedure Terminology (CPT5) 09 Health Care Financing Administration Common Procedural Coding System (HCPCS) 10 Pharmacy Practice Activity Classification (PPAC) 11 National Pharmaceutical Product Interface Code (NAPPI) 12 International Article Numbering System (EAN) 13 Drug Identification Number (DIN) EN European Article Number (EAN) EO GTIN EAN/UCC HI Health Care Industry Bar Code (HIBC) N4 Physician Administered Drug (PAD) NDC ON Customer Order Number UK UPC / EAN Shipping Container Code UP UPC Consumer Package Code 99 Other Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 436-E1, 'Product/Service ID Qualifier'	

Revisions and History:	**Date**	**Description**

93.2 DRUG UNIT OF MEASURE

COBOL Name:	F35C-DRUG-UNIT-OF-MEASURE	
Location in Main Type Segment:	**062-063**	
Definition:	The Drug Unit of Measure field specifies the units in which a value is being expressed, or manner in which a measurement has been taken.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:	Taken from the NCPDP Data Dictionary 5.1: Blank = Not Specified 01 = Inches (in) 02 = Centimeters (cm) 03 = Pounds (lb) 04 = Kilograms (kg) 05 = Celsius (C) 06 = Fahrenheit (F) 07 = Meters Squared (m2) 08 = Milligrams per Deciliter (mg/dl) 09 = Units per Milliliter (U/ml) 10 = Millimeters of Mercury (mmHg) 11 = Centimeters Squared (cm2) 12 = Millimeters per Minute (ml/min) 13 = Percentage (%) 14 = Milliequivalent (mEq/ml) 15 = International Units per Liter (IU/L) 16 = Micrograms per Milliliter (mcg/ml) 17 = Nanograms per Milliliter (ng/ml) 18 = Milligrams per Milliliter (mg/ml) F2 = International Unit GM = Gram GR = Gram ML = Milliliter UN = Unit Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 600-28, 'Unit of Measure'	
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

93.3 DRUG BASIS OF COST DETERMINATION

COBOL Name:	F35C-DRUG-BASIS-OF-COST-DETERM	
Location in Main Type Segment:	**064-065**	
Definition:	Drug Basis of Cost Determination indicates whether or not drug dispensed was purchased under a Disproportionate Share/Public Health Service contract.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Space or 00 = Not Specified 09 = Other (Other means Disproportionate Share/Public Health Service contract in the Medi-Cal POS Network Specifications). Identifies 340B/PHS drugs. NR = Specific to Cal-Optima and the Partnership Health Plan, for claims reported by Kaiser Permanente and Molina Health Care that are non-reportable for rebate purposes.	
Comments and Special Considerations:	Taken from the NCPDP Data Dictionary 5.1 using field 223, 'Basis of Cost Determination'. We have declared 'Other' to mean Disproportionate Share/Public Health Service contract in the Medi-Cal POS Network Specifications. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 223, 'Basis of Cost Determination' (For Cal-Optima and the Partnership Health Plan, claims reported by Kaiser Permanente and Molina Health Care, enter 'NR' into this field)	
Revisions and History:	**Date**	**Description**

93.4 DRUG REFILL NUMBER

COBOL Name:	F35C-DRUG-REFILL-NUMBER	
Location in Main Type Segment:	**066-067**	
Definition:	Drug Refill Number indicates the number of refills of this prescription.	
Format Description:	Data Type:	Numeric.
	Display Length:	2
	Storage Length:	2
	Picture Clause:	9(02)
Allowed Values:	Numeric	
Comments and Special Considerations:	For more information on FI, see DRUG REFILL NUMBER, Appendix K. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 403-D3, 'Fill Number'	
Revisions and History:	**Date**	**Description**

93.5 DRUG PART D EXCLUDED INDICATOR

COBOL Name:	F35C-PART-D-EXCLUDED-IND	
Location in Main Type Segment:	**068-068**	
Definition:	For future use.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:		
Comments and Special Considerations:	See Appendix A, F35C-DRUG-PART-D-EXCLUDED-IND-Edit for more information.	
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

93.6 DRUG NCPDP REJECT CODE

COBOL Name:	F35C-NCPDP-REJECT-CODE	
Location in Main Type Segment:	**069-071**	
Definition:	The Drug NCPDP Reject Code indicates the reason for claim rejection.	
Format Description:	Data Type:	Character
	Display Length:	3
	Storage Length:	3
	Picture Clause:	X(03)
Allowed Values:	3 digit alphanumeric per the NCPDP standards.	
Comments and Special Considerations:	This field is the primary/first code from the EDS 34 file record, which allows up to five codes. See Appendix A, F35C-DRUG-NCPDP-REJECT-CODE-Edit for more information.	
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

93.7 DRUG DISPENSING FEE CODE

COBOL Name:	F35C-DRUG-DISPENSING-FEE-CODE	
Location in Main Type Segment:	**072-072**	
Definition:	Drug dispensing fee code indicates how a product was priced. Since different categories of products are priced in different ways, the dispensing fee code can be useful to identify those classes of products.	
Format Description:	Data type:	Character
	Display length:	1
	Storage length:	1
	Picture clause:	X(01)
Allowed Values:	As of June 23, 2008, the current valid dispensing fee codes are as follows: 'A' – Over-the-counter fixed fee. 'B' – Prescription fixed fee. 'F' – Prescription fixed fee. 'I' – Incontinence medical supply. 'J' – Nutritional supplement. 'M' – Medical supply. 'P' – Diabetic testing supplies. 'S' – Blood factors. Note that in the past other values have been used, and some of the current values had somewhat different meanings in the past. All other values are invalid.	
Comments and Special Considerations:	The Dispensing Fee Code on the Formulary File indicates how a product is priced, and by extension, what type of product it is. It can be used to determine if a product billed for is a medical supply, or some other kind of product. The field will be checked during pricing, and compound drug claims with medical supplies will be denied unless billed with the Process for Approved Ingredients field set to Y, in which case the ingredient will be priced at zero.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised
	For the history of this element, see Appendix G, DRUG DISPENSING FEE CODE.	

93.8 DRUG DAYS SUPPLY

COBOL Name:	F35C-DRUG-DAYS-SUPPLY	
Location in Main Type Segment:	**073-074**	
Definition:	Drug Days Supply identifies the number of days that the prescription covered.	
Format Description:	Data Type:	Packed
	Display Length:	3
	Storage Length:	2
	Picture Clause:	S9(03) COMP-3
Allowed Values:	Numeric	
Comments and Special Considerations:	The prescription volume is reported in data element Drug Units. This field shows how many days that volume covers. See Appendix A, F35C-DRUG-DAYS-SUPPLY-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 405-D5, 'Days Supply'	
Revisions and History:	**Date**	**Description**
	For the history of this element, see Appendix G, DRUG DAYS SUPPLY.	

93.9 DRUG UNIT PRICE

COBOL Name:	F35C-DRUG-UNIT-PRICE	
Location in Main Type Segment:	**075-079**	
Definition:	Price per unit of drug.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(07)V99 COMP-3
Allowed Values:	Numeric (monetary value).	
Comments and Special Considerations:	Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 211, 'Average Wholesale Unit Price'	
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

93.10 DRUG UNITS

COBOL Name:	F35C-DRUG-UNITS	
Location in Main Type Segment:	**080-085**	
Definition:	Drug unit metric quantity	
Format Description:	Data Type:	Packed
	Display Length:	11
	Storage Length:	6
	Picture Clause:	S9(08)V999 COMP-3
Allowed Values:	Numeric See Appendix A, F35C-DRUG-UNITS-Edit for more information.	
Comments and Special Considerations:	Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 442-E7, 'Quantity Dispensed'	
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

93.11 DRUG PROCEDURE INDICATOR

COBOL Name:	F35C-DRUG-PROCEDURE-INDICATOR	
Location in Main Type Segment:	**086-086**	
Definition:	Procedure Indicator identifies the type of procedure code or drug code present in the procedure code field.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	3 = UPN (Universal Product Number), UPC (Universal Product Code), PIN (Product Identification Number), HRI (Health Related Item), NDC (National Drug Code) codes for drugs, NDC medical supply codes and state drug code IDs for Medical Supplies. See Appendix A, F35C-MEDICAL-SUPPLY-IND-Edit and DRUG PROCEDURE AREA for more information on Medical Supply claims.	
Comments and Special Considerations:	See Appendix D, Comparison of Paid Claims Fields for Various Plan Codes. See Appendix A, F35C-DRUG-PROCEDURE-INDICATOR-Edit for more information. Information related to FI (fiscal intermediary) can be found in Appendix K, FI Procedure Indicator.	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, Procedure Indicator	

93.12 DRUG PROCEDURE CODE

COBOL Name:	F35C-DRUG-PROCEDURE-CODE	
Location in Main Type Segment:	**087-106**	
Definition:	Procedure Code or Drug Type identifies the exact service rendered or the specific drug or medical supply dispensed on a drug claim.	
Format Description:	Data Type:	Character
	Display Length:	20
	Storage Length:	20
	Picture Clause:	X(20)
Allowed Values:	The Drug Procedure Indicator determines the type of procedure. Because the Drug Procedure Code field is designed to contain only a drug code, the Drug Procedure Indicator can only be '3'. The following format is used. The field is 20 bytes. The formats below use the bytes required then fill the rest with trailing blanks. For example, an NDC code would occupy the first 11 bytes with the last 9 bytes filled with blanks. When Procedure Indicator is: — Procedure Area is: 3 - National Drug Code (NDC) — 11 characters 3 - Universal Product Code (UPC) — 11characters 3 - Health Related Industries Code (HRI) — 11 characters 3 - State Drug Code after 3/94 — 11 characters Length / Offset / Possible Values 4 bytes, 1 thru 4 LOW VALUES 4 bytes, 5 thru 8 Numeric, 1 byte, 9 Alpha (indicates drug strength) 2 bytes, 10 & 11 Alphanumeric (drug manufacturer's code) See Comments and Special Considerations 3 - Compound drugs after 3/94 — '99999999996' or '0 ', that is a zero followed by 10 spaces and compound drug code = 2. 3 – Universal product Number (UPN) — 19 characters See Appendix A, F35C-DRUG-PROCEDURE-CODE-Edit for more information.	

Comments and Special Considerations:	See Comparison of Paid Claims Fields for Various Plan Codes, Appendix D for field interrelationships. The F35C-DRUG-PROCEDURE-CODE field is a multiple-use part of the record. The use and layout of the field are determined by the value in the field F35C-PROCEDURE-INDICATOR.
	
	When the value of the F35C-DRUG-PROCEDURE-CODE is '3' indicating the product is identified by a NDC, UPN, HRI, PIN, UPC or state drug code, one of the following layouts are used for the F35C-DRUG-PROCEDURE-CODE.
	
	Layout one:
	`20 F35C-NDC-UPC-HRI-CODE.`
	`25 F35C-NDC-UPC-HRI-LABELER PIC X(05).`	

```
        25  F35C-NDC-UPC-HRI-PRODUCT      PIC X(04).
        25  F35C-NDC-UPC-HRI-PACKAGE      PIC X(02).
    20  FILLER                            PIC X(09).
```

Layout two:

```
    20  F35C-MEDI-CAL-CODE-PREFIX         PIC X(04).
        88 F35C-MEDI-CAL-DRUG          VALUE LOW-VALUES.
    20  F35C-MEDI-CAL-DRUG-AREA.
        25  F35C-MEDI-CAL-DRUG-CODE.
            30  F35C-MEDI-CAL-DRUG-CD     PIC X(04).
            30  F35C-MEDI-CAL-DRUG-STR    PIC X(01).
        25  F35C-MEDI-CAL-DRUG-MFG        PIC X(02).
    20  FILLER                            PIC X(09).
```

Layout three:

```
        25  F35C-DRUG-UPN-NUMBER      PIC X(19).
        25  F35C-DRUG-UPN-BILLER      PIC X(01).
```

If the value of the field F35C-MEDI-CAL-CODE- PREFIX is LOW-VALUES (this corresponds with the first four bytes of F35C- DRUG-PROCEDURE-CODE), then the product is identified by the values in the field F35C-MEDI-CAL-DRUG-CODE, otherwise the product is identified by the values in the field F35C-NDC-UPC-HRI-CODE or F35C-DRUG-UPN-NUMBER.

If the value of the field F35C-MEDI-CAL-CODE-PREFIX is LOW-VALUES, then the field F35C-MEDICAL-SUPPLY-INDICATOR must be ‘Y’ and the values of the field F35C-MEDI-CAL-DRUG-CD must fall in the range ‘9900’ thru ‘9999’. The value ‘Y’ in the field F35C-MEDICAL-SUPPLY-INDICATOR does not always indicate a state drug code is used. State drug codes are used only when the F35C-MEDICAL-SUPPLY-INDICATOR is set to ‘Y’ and the field F35C-MEDI-CAL-CODE-PREFIX contains LOW-VALUES.

Information related to FI (fiscal intermediary) can be found in FI Procedure Code

Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 407-D7, ‘Product/Service ID’

Revisions and History:

Date	Description
6/27/2007	New data element

For the history of this data element, see Appendix G, PROCEDURE CODE .

93.13 DRUG PRODUCT ID

COBOL Name:	F35C-DRUG-PRODUCT-ID	
Location in Main Type Segment:	**087-106**	
Definition:	Identifying number for a drug.	
Format Description:	Data Type:	Character
	Display Length:	20
	Storage Length:	20
	Picture Clause:	X(20)
Allowed Values:	May have a product ID number or free-form text up to 20 characters long. When the Procedure Indicator is '3' the following codes are used. National Drug Code(NDC) Universal Product Code (UPC) Health Related Industries Code (HRI)	
Comments and Special Considerations:	The NCPDP 5.1 standard specifies that this field (Field 407-D7) is 19 bytes in length. This field is 20 bytes in length to accommodate a future anticipated size change. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 407-D7, 'Product/Service ID' If compound drugs are reported with multi-ingredient processing, the Claim Segment will contain '0' for field 436-E1 (Product/Service ID Qualifier) and '2' for field 406-D6 (Compound Code). The Compound Segment will contain each NDC and quantity used in preparing the compound. If compound drugs are not reported with multi-ingredient processing, the Compound Segment is not used and the NDC of the most expensive ingredient will be in field 436-E1 (Product/Service ID Qualifier), '2' in field 406-D6 (Compound Code).	
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

93.13.1 DRUG UNIVERSAL PRODUCT NUMBER (UPN)

COBOL Name:	F35C-DRUG-UPN-NUMBER	
Location in Main Type Segment:	**087-105**	
Definition:	UPN codes are used to bill medical supply claims with either an NDC, UPC, or HIBCC code. The format varies per code source.	
Format Description:	Data Type:	Character
	Display Length:	19
	Storage Length:	19
	Picture Clause:	X(19)
Allowed Values:	Alphanumeric up to 19 digits; based on NDC, UPC, and HIBCC published code values.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

93.13.2 DRUG NATIONAL DRUG CODE (NDC)

COBOL Name:	F35C-DRUG-NDC-CODE	
Location in Main Type Segment:	**087-097**	
Definition:	NDC drug code	
Format Description:	Data Type:	Character
	Display Length:	11
	Storage Length:	11
	Picture Clause:	X(11)
Allowed Values:	Valid NDC codes.	
Comments and Special Considerations:	Please refer to U.S. Food and Drug Administration web site http://www.fda.gov/cder/ndc/ for the National Drug Code directory. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 407-D7, 'Product/Service ID'	
Revisions and History:	**Date**	**Description**

93.13.3 DRUG MEDI-CAL DRUG CODE

COBOL Name:	F35C-DRUG-MEDI-CAL-DRUG-CODE	
Location in Main Type Segment:	**091-095**	
Definition:	Medi-Cal drug code	
Format Description:	Data Type:	Character
	Display Length:	5
	Storage Length:	5
	Picture Clause:	X(05)
Allowed Values:	▪ 4 numeric digits followed by 1 alphabetic letter ▪ 4-byte prefix, which must be low value	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

93.13.4 DRUG MEDI-CAL DRUG MANUFACTURER

COBOL Name:	F35C-DRUG-MEDI-CAL-DRUG-MFG	
Location in Main Type Segment:	**096-097**	
Definition:	Drug manufacturer	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Alpha-numeric	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

94.0 OTHER PROCEDURE AREA

COBOL Name:	F35C-OTHER-PROCEDURE-AREA	
Location in Main Type Segment:	**114-139**	
Definition:	This area is for reporting information on a service or product with a procedure code that is not longer than 5 characters, such as HCPCS or CPT-4 codes.	
Format Description:	Data Type:	Varies
	Display Length:	26
	Storage Length:	26
	Picture Clause:	
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

94.1 OTHER PRODUCT ID QUALIFIER

COBOL Name:	F35C-OTHR-PROD-ID-QUALIFIER	
Location in Main Type Segment:	**114-115**	
Definition:	Other Product ID Qualifier identifies the type of code used to identify a procedure code (e.g., NDC, HRI, and UPN, etc, or other). At this time the only type of numeric identifier used in Medi-Cal is 03 (NDC number).	
Format Description:	Data type:	Character
	Display length:	2
	Storage length:	2
	Picture clause:	X(02)
Allowed Values:	03 National Drug Code (NDC) Space Not specified 00 Not specified 99 Other	
Comments and Special Considerations:	Since the only value in use is 03 (NDC) and the NDC cannot be reported in the Other Procedure Area, the field should be blank at this time.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

94.2 OTHER PROCVAL INDICATOR

COBOL Name:	F35C-OTHR-PROCVAL-INDICATOR	
Location in Main Type Segment:	**116-117**	
Definition:	For future use.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

94.3 OTHER UNITS

COBOL Name:	F35C-OTHR-UNITS	
Location in Main Type Segment:	**118-123**	
Definition:	Metric quantity	
Format Description:	Data Type:	Packed
	Display Length:	11
	Storage Length:	6
	Picture Clause:	S 9(8) V999 COMP-3
Allowed Values:	Numeric See Appendix A, F35C-OTHR-UNITS-Edit for more information.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

94.4 OTHER PROCEDURE TYPE

COBOL Name:	F35C-OTHR-PROCEDURE-TYPE	
Location in Main Type Segment:	**124-124**	
Definition:	The Other Procedure Type field is used to indicate a service type where multiple policy/pricing for the same HCPCS code exists.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	1 SMA I Injection 3 Opthalmology 4 Cost Center (Ancillary – Inpatient) J Anesthesia K Surgery L Radiology M Lab N Medicine O Assistant Surgeon P Podiatrist	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

94.5 OTHER PROCEDURE INDICATOR

COBOL Name:	F35C-OTHR-PROCEDURE-INDICATOR	
Location in Main Type Segment:	**125-125**	
Definition:	Other Procedure Indicator identifies the types of product code in the other procedure code field.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Numeric. 0 = Current Dental Terminology (CDT) (as of 12/01/2007) (Prior to 7/1/1993, this was Delta Dental Table of Dental Procedures. From 7/1/1993 to 11/30/2007, dental services were reported using HCPCS codes.) 1 = UB-92s ([Uniform Billing – 1992] Uniform Billing codes began on January 1, 1992.) 2 = SMA [Scheduled Maximum Allowance] (replaced by HCPCS Levels II and III except for special rural health clinic/federally qualified health center codes). **Note:** EPSDT (Early Periodic Screening, Diagnosis and Treatment) claims always use this indicator. 4 = CPT-4 (as of 11/1/87 -- Current Procedure Terms: A systematic listing and coding of healthcare procedures and services performed by clinicians. The American Medical Association's CPT-4 refers to procedures delivered by physicians.) 6 = California Health Facilities Commission (CHFC) [out of date?] 7 = Los Angeles Waiver/L. A. Waiver [out of date?] 8 = Short-Doyle/Medi-Cal (only on Plan Code 8) 9 = HCPCS Levels II and III (effective on October 1, 1992)Space = EDS Inpatient long-term care (LTC) Note: the procedure code field is a space, so the accommodation code is used. See Appendix A, F35C-OTHR-PROCEDURE-INDICATOR-Edit for more information.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, Procedure Indicator	

94.6 OTHER PROCEDURE CODE

COBOL Name:	F35C-OTHR-PROCEDURE-CODE	
Location in Main Type Segment:	**126-130**	
Definition:	Other Procedure Code identifies the exact service or product rendered. It is used to report a procedure code that is not longer than 5 characters, such as HCPCS or CPT-4 codes.	
Format Description:	Data Type:	Character
	Display Length:	5
	Storage Length:	5
	Picture Clause:	X(05)
Allowed Values:	Any procedure code, 5 characters or less, such as dental CDT4, UB-92, CPT-4, or HCPCS. See Appendix A, F35C-OTHR-PROCEDURE-CODE-Edit for more information.	
Comments and Special Considerations:	Information related to FI (fiscal intermediary) can be found in FI Procedure Code	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, PROCEDURE CODE .	

94.7 OTHER INPATIENT LOCAL CODE

COBOL Name:	F35C-OTHR-INPATIENT-LOCAL-CODE	
Location in Main Type Segment:	**136-139**	
Definition:	This is the local Inpatient Accommodation code before HIPAA required national revenue codes. Note: Prior to SDN 6005 (NPI), the system cross walked the national revenue code to its equivalent local accommodation code, where the national code can split into different local codes based on surgical code and other parameters. Otherwise, the local accommodation code and the revenue code would be equal. After the implementation of NPI, these two codes are always equal as the system no longer crosswalks revenue codes. The revenue type is used to make the distinction between codes.	
Format Description:	Data Type:	Character
	Display Length:	4
	Storage Length:	4
	Picture Clause:	X(04)
Allowed Values:	All numeric values are accepted, but the following are valid values: '0071' '0072' '0073' '0074' '0083' THRU '0089' '0091' '0092' '0095' '0097' '0099' '0111' THRU '0114' '0117' THRU '0119' '0121' THRU '0124' '0127' THRU '0129' '0131' THRU '0134' '0137' THRU '0139' '0151' THRU '0154' '0157' THRU '0159' '0169' '0170' THRU '0174' '0200' THRU '0204' '0206' THRU '0212' '0214' '0219' '0790' '1085' '1097' '1111' THRU '1114' '1117' THRU '1119' '1121' THRU '1124' '1127' THRU '1129' '1131' THRU '1134' '1137' THRU '1139' '1151' THRU '1154' '1157' THRU '1159' '1170' THRU '1174'	

	'1200' THRU '1204' '1206' THRU '1212' '1214' '1219'. The following local Ancillary Service codes are also valid: '0250' THRU '0255' '0257' THRU '0259' '0270' THRU '0272' '0274' THRU '0276' '0278' '0279' '0290' THRU '0293' '0299' THRU '0302' '0304' THRU '0307' '0310' '0311' '0314' '0320' THRU '0324' '0329' THRU '0333' '0335' '0339' THRU '0342' '0349' THRU '0352' '0359' THRU '0362' '0367' '0369' THRU '0372' '0374' '0379' THRU '0387' '0389' THRU '0391' '0400' THRU '0403' '0409' '0410' '0412' '0413' '0419' '0420' '0430' '0439' '0440' '0449' '0450' '0460' '0459' '0470' THRU '0472' '0479' '0481' '0489' '0610' THRU '0612' '0619' '0621' '0622' '0630' '0631' THRU '0636' '0710' '0720' '0721' '0724' '0729' THRU '0731' '0740' '0750' '0800' THRU '0804' '0809' '0922' '0949'.
Comments and Special Considerations:	
Revisions and History:	**Date** / **Description** 6/27/2007 / New data element /

95.0 PROCEDURE MODIFIERS OR TEETH

COBOL Name:	F35C-PROC-MODIFIERS-OR-TEETH	
Location in Main Type Segment:	**140-147**	
Definition:	For Dental Claim - Tooth or Modifier determines tooth or mouth area being treated. For Medical/Physician and Outpatient claims - Tooth or Modifier determines any special external circumstances connected to the service.	
Format Description:	Data Type:	Character
	Display Length:	08
	Storage Length:	08
	Picture Clause:	X(08)
Allowed Values:	Consists of 1 to 4 2-character codes. Must be > = spaces.	
Comments and Special Considerations:	See Approved Modifiers, Appendix B for a list of the approved modifiers. See Appendix H for Delta Dental Tooth codes. For more information on FI, see FI Tooth or Modifier, Appendix K.	
Revisions and History:	**Date**	**Description**

96.0 ACCOMMODATION CODE

COBOL Name:	F35C-ACCOMMODATION–CODE	
Location in Main Type Segment:	**148-150**	
Definition:	Accommodation Code identifies type of accommodation or ancillary service being billed for inpatient claims only.	
Format Description:	Data Type:	Character
	Display Length:	3
	Storage Length:	3
	Picture Clause:	X(03)
Allowed Values:	See Appendix N. LTC Accommodation Codes for the long term care codes.	
Comments and Special Considerations:	The accommodation code is used to denote long term care facility accommodations. See Comparison of Paid Claims Fields for Various Plan Codes, Appendix D for an overview of various plan code fields interrelationships. For more information on FI, see ACCOMODATION CODE, Appendix K. See Appendix A, F35C-ACCOMMODATION-CODE-Edit for more information.	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, Accommodation Code.	

97.0 DRUG MANUFACTURER

COBOL Name:	F35C-DRUG-MANUFACTURER	
Location in Main Type Segment:	**151-152**	
Definition:	Drug Manufacturer identifies the manufacturer of the pharmaceutical on drug claims.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:	This drug manufacturer field is no longer applicable upon implementation of the 11-byte procedure code field. The procedure code field will have the manufacturer code in the last two bytes. For more information on FI, see DRUG MANUFACTURER, Appendix K.	
Revisions and History:	**Date**	**Description**

98.0 PRESCRIPTION NUMBER

COBOL Name:	F35C-PRESCRIPTION-NUMBER	
Location in Main Type Segment:	**153-160**	
Definition:	Prescription Number identifies pharmacies internal invoice number on pharmaceutical claims.	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:	For more information on FI, see FI Prescription Number, Appendix K. See Appendix A, F35C-PRESCRIPTION-NUMBER-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 402-D2, 'Prescription/Service Reference No.'	
Revisions and History:	**Date**	**Description**

99.0 COPAY AMOUNT

COBOL Name:	F35C-COPAY-AMOUNT	
Location in Main Type Segment:	**161-165**	
Definition:	The co-payment amount is to be collected by or obligated to the provider at the time the service is rendered.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(07)V99 COMP-3
Allowed Values:	Numeric	
Comments and Special Considerations:	Co-payment may be collected from Medi-Cal beneficiaries at the option of the provider. The provider in addition to his Medi-Cal payment retains co-payment amounts. Certain categories of beneficiaries are exempt from one or all types of co-payment. The co-payment amount is to be collected by or obligated to the provider at the time the service is rendered. The amounts are in addition to the usual provider reimbursement and no deduction will be made from the amounts otherwise approved by EDS for payment to the provider. The collection of the co-payment by the provider is optional. A provider of service cannot, under law, deny care or services to an individual solely because of that person's inability to co-pay. The individual does, however, remain liable to the provider for any co-payment amount owed. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 505-F5, 'Patient Pay Amount'	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, COPAY AMOUNT.	

100.0 OHC COPAY AMOUNT

COBOL Name:	F35C-OHC-COPAY-AMOUNT	
Location in Main Type Segment:	**166-170**	
Definition:	Money field used to indicate amount of OHC copay for Part D claims.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(07)V99 COMP-3
Allowed Values:	Numeric (monetary value).	
Comments and Special Considerations:	Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 352-NQ, 'Other Payer-Patient Responsibility Amount'	
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

101.0 PRICE RESTRICTION

COBOL Name:	F35C-PRICE-RESTRICTION	
Location in Main Type Segment:	**171-171**	
Definition:	Price Restriction identifies drugs with dispensing restrictions for Pharmacy claims only.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	0 or space no restrictions 1 restrictions	
Comments and Special Considerations:	Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 272, 'MAC Reduced Indicator'	
Revisions and History:	**Date**	**Description**

102.0 RENDERING / OPERATING PROVIDER NUMBER

COBOL Name:	F35C-RENDER-OPERATING-PROV-NUM	
Location in Main Type Segment:	**172-181**	
Definition:	Rendering Operating Provider Number identifies the provider whom the recipient was to as a result of screening by another provider.	
Format Description:	Data Type:	Character
	Display Length:	10
	Storage Length:	10
	Picture Clause:	X(10)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:	This field can contain NPI or other provider numbers such as the Medi-Cal provider number. Provider numbers are assigned primarily to facilitate billing activities, so a 'provider' may have multiple ID numbers. For example, a hospital might have an inpatient number, outpatient number and a long term care number. There is some standardization, such as long-term care numbers beginning LTC, but there are many exceptions. The individual physician numbers have a feature which distinguishes how many offices s/he has: Right most position = 0 = the physician works for a group provider Right most position = 1 = one office Right most position = 2 = two offices, etc. See Appendix Q, Provider Naming/Number System for the list of provider naming and number acronyms. Information related to FI can be found in FI Provider Number See Appendix A, F35C-RENDER-OPERATING-PROV-NUM-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 201-B1, 'Service Provider ID'	
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

103.0 RENDERING / OPERATING PROVIDER TAXONOMY

COBOL Name:	F35C- REND-OPER-PROV-TAXONOMY	
Location in Main Type Segment:	**182-191**	
Definition:	Rendering Operating Provider Taxonomy identifies provider type, classification, and specialization for the rendering or operating provider. The Health Care Provider Taxonomy code set is a collection of unique alphanumeric codes, ten characters in length. The code set is structured into three distinct "Levels" including Provider Type, Classification, and Area of Specialization.	
Format Description:	Data Type:	Character
	Display Length:	10
	Storage Length:	10
	Picture Clause:	X(10)
Allowed Values:	Health Care Provider Taxonomy code list (provider specialty code) is available on the Washington Publishing Company web site: http://www.wpc-edi.com/content/view/515/229 The Blue Cross Blue Shield Association and ASC X12N TG2 WG15 maintains this taxonomy. Must be > = spaces.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

104.0 RENDERING / OPERATING PROVIDER OWNER NUMBER

COBOL Name:	F35C-REND-OPER-PROV-OWNER-NUM	
Location in Main Type Segment:	**192-193**	
Definition:	The owner number is an incremental numeric indicator that identifies the specific owner of an organizational NPI, because they can have multiple owners for different time periods.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Alphanumeric. Must be > = spaces.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

105.0 REFERRING / PRESCRIBING PROVIDER NUMBER

COBOL Name:	F35C-REF-PRESCRIB-PROV-NUM	
Location in Main Type Segment:	**194-203**	
Definition:	For drug claims, this is the number of the prescribing provider. For other claim types, this is the number of the referring provider.	
Format Description:	Data Type:	Character
	Display Length:	10
	Storage Length:	10
	Picture Clause:	X(10)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:	This field can contain NPI or other provider numbers such as the Medi-Cal provider number. Provider numbers are assigned primarily to facilitate billing activities, so a 'provider' may have multiple ID numbers. For example, a hospital might have an inpatient number, outpatient number and a long term care number. There is some standardization, such as long-term care numbers beginning LTC, but there are many exceptions. The individual physician numbers have a feature which distinguishes how many offices s/he has: Right most position = 0 = the physician works for a group provider Right most position = 1 = one office Right most position = 2 = two offices, etc. See Appendix Q, Provider Naming/Number System for the list of provider naming and number acronyms. Information related to FI can be found in REFERRING/**PRESCRIBING PROVIDER NUMBER**, Appendix K. See Appendix A, F35C-REFER-PRESCRIB-PROV-NUM-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 411-DB, 'Prescriber ID'	
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element
	For the history of this data element, see Appendix G, REFERRING/**PRESCRIBING PROVIDER NUMBER**.	

106.0 REFERRING / PRESCRIBING PROVIDER TAXONOMY

COBOL Name:	F35C-REFER-PRESC-PROV-TAXONOMY	
Location in Main Type Segment:	**204-213**	
Definition:	For drug claims, this is the taxonomy of the prescribing provider. For other claim types, this is the taxonomy of the referring provider. The Health Care Provider Taxonomy code set is a collection of unique alphanumeric codes, ten characters in length. The code set is structured into three distinct "Levels" including Provider Type, Classification, and Area of Specialization.	
Format Description:	Data Type:	Character
	Display Length:	10
	Storage Length:	10
	Picture Clause:	X(10)
Allowed Values:	Health Care Provider Taxonomy code list (provider specialty code) is available on the Washington Publishing Company web site: http://www.wpc-edi.com/content/view/515/229 The Blue Cross Blue Shield Association and ASC X12N TG2 WG15 maintains this taxonomy. Must be > = spaces.	
Comments and Special Considerations:	Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 296, 'Prescriber Taxonomy'	

Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

107.0 EPSDT REFERRAL CODE

COBOL Name:	F35C-EPSDT-REFERR-CDS	
Location in Main Type Segment:	**214-215**	
Definition:	EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Referral Code identifies if this claim is a CHDP screen-related service; e.g., if a CHDP (Child Health and Disability Prevention) referral preceded this claim.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	01 = CHDP screen-related service 00 = Not a CHDP screen-related service	
Comments and Special Considerations:	The CHDP (Child Health and Disability Prevention) program is the name for California's EPSDT (Early and Periodic Screening, Diagnosis and Treatment) program. If a Medi-Cal provider enters a '3' in the family planning/CHDP box on claim form 40-1 or HCFA-1500, then the claim is for a CHDP screen related service.	
Revisions and History:	**Date**	**Description**

108.0 COPAY INDICATOR

COBOL Name:	F35C-COPAY-IND	
Location in Main Type Segment:	**216-216**	
Definition:	Copay Indicator determines the kind of copay	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	N or space or low-values = No Copay Deduction A = Adjusted Copay (not currently used) H = Copay taken on another detail L = Limited Copay (allowable less than Copay) S = Standard Copay applied Z = Copay applicable but allowable was zero **Note:** Only 'L' and 'S' will have valid dollar amounts in the Copay amount field. The remainder will be set to zero dollars.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, Co-pay Indicator.	

109.0 FI TYPE OF SERVICE

COBOL Name:	F35C-FI-TOS	
Location in Main Type Segment:	**217-217**	
Definition:	FI Type of Service characterizes the type of service with which a procedure code is associated.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:	For more information on FI, see FI Type of Service, Appendix K.	
Revisions and History:	**Date**	**Description**

110.0 DETAIL OTHER COVERAGE AMOUNT

COBOL Name:	F35C-DET-OTHER-COVERAGE-AMOUNT	
Location in Main Type Segment:	**218-222**	
Definition:	Detail Other Coverage Amount identifies the amount of money paid by an insurance carrier or third party for this service. Does not include Medicare payment.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(07)V99 COMP-3
Allowed Values:	Numeric (monetary value). If there is a negative adjustment indicator (2,3,5), then must be < = 0.	
Comments and Special Considerations:	Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 566-J5, 'Other Payer Amount Recognized'	
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, DETAIL OTHER COVERAGE AMOUNT	

111.0 ADDITIONAL FEE

COBOL Name:	F35C-ADDITIONAL-FEE	
Location in Main Type Segment:	**223-227**	
Definition:	Used to add additional payment to allowed amount and track separately.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(07)V99 COMP-3
Allowed Values:	Numeric (monetary value).	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

112.0 ORIGINAL PLACE OF SERVICE

COBOL Name:	F35C-ORIG-POS-2	
Location in Main Type Segment:	**228-229**	
Definition:	Original Place of Service identifies where the service was rendered.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Alphanumeric or space. This coding scheme is different from the DHCS coding scheme and reflects the codes used on the claim forms by the provider. There are two sets of place of service (POS) codes that will be found here depending on whether the HCFA-1500 was used or another claim form was used. The HCFA-1500 POS codes are two-digit codes. The other POS codes are one-digit codes and will have a trailing space to fill this two-byte field. <u>One–digit POS codes with a trailing space used on all but the form HCFA-1500</u> 1 Office 2 Home 3 Inpatient hospital 4 Nursing facility level B (SNF) 5 Outpatient hospital 6 Independent laboratory 7 Other 8 Independent kidney treatment center 9 Clinic A Surgery clinic B Emergency room C Nursing facility level A (ICF) F Subacute care facility G Intermediate Care Facility-Developmentally Disabled H Intermediate Care Facility-Developmentally Disabled-habilitative I Intermediate Care Facility-Developmentally Disabled- Nursing Origin Place of Service <u>Other one-digit POS codes with a trailing space (continued)</u> J Non-home K Mobile Van M Pediatric Subacute N Non-ICF/SNF for drug claims only <u>HCFA-1500 two-digit POS Codes</u> 11 Office 12 Patient's home 21 Inpatient hospital	

<table>
<tr><td></td><td>22 Outpatient hospital
23 Emergency room (hospital)
24 Ambulatory surgical center
25 Birthing center
26 Military treatment center (Not Valid for Medi-Cal Billing)
31 Skilled nursing facility
32 Nursing home/nursing facility
33 Custodial care facility(Not Valid for Medi-Cal Billing)
34 Hospice(Not Valid for Medi-Cal Billing)
41 Ambulance (land)
42 Ambulance (air or water)
51 Inpatient psychiatric facility(Not Valid for Medi-Cal Billing)
52 Day care facility/psych. Facility(Not Valid for Medi-Cal Billing)
53 Community mental health center
54 Specialized treatment center/intermediate care
55 Residential treatment center/substance abuse
56 Psychiatric residential treatment center(Not Valid for Medi-Cal Billing)
61 Comprehensive inpatient rehab facility(Not Valid for Medi-Cal Billing)
62 Comprehensive outpatient rehab facility
65 Independent kidney disease treatment center
71 State or local public health clinic
72 Rural health clinic
81 Independent laboratory
91 Nursing Facility Level B (Adult Subacute)
92 Intermediate Care Facility (Developmentally Disabled, (ICF/DD))
93 Intermediate Care Facility (Developmentally Disabled habilitative, ICF/DD-H)
96 Pediatric Subacute
97 Transitional Inpatient Care (effective 1/1/96)
99 Other</td></tr>
<tr><td>Comments and Special Considerations:</td><td>For more information on FI, see FI Original Place of Service, Appendix K.

See Appendix A, F35C-ORIG-POS-2-Edit for more information.</td></tr>
<tr><td>Revisions and History:</td><td><table><tr><th>Date</th><th>Description</th></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>For the history of this data element, see Appendix G, ORIGINAL PLACE OF SERVICE</td></tr>
</table>

113.0 SMART KEY

COBOL Name:	F35C-SMART-KEY	
Location in Main Type Segment:	**230-253**	
Definition:	First Databank Smart Key describes the specifics of a drug. It is used for both NDC and state drug codes.	
Format Description:	Data Type:	Character
	Display Length:	24
	Storage Length:	24
	Picture Clause:	X(24)
Allowed Values:	Field (as of 1993) Bytes Generic Therapeutic Class (GTC) (GTC) broad classification; e.g. 20=Anti-infective 2 Specific Therapeutic Class (STC) Specific classification; e.g.0478=Tetracycline 4 Generic Name/ (HICL) Hierarchical Ingredient Code List identifies the specific Generic entity; e.g. 04003=Tetracycline HCI 5 Drug Strength; (STR) e.g. 0600=250mg 4 Dosage Form (DOSE) e.g. 500=capsule 3 Route of Administration (RT) e.g. 01=oral 2 Package Size (PS) e.g. 008=100each 3 Unit Dose/Unit of Use (UDUU) Identifies special packaging; 0 = doesn't have unit dose or use 1 = unit dose 2 = unit of use 1	
Comments and Special Considerations:	The strength is defined two ways. If the range values are 0**001-099**9, then the value represents milligrams. So a value of 0005 is less than 0500, and 0005 means 0.02 mg and 0550 equals 130 mg. The other range of 1000 to 2000 is a percentage. That means that a SKEY-STG of 1000 is less than a SKEY-STR of 1100. So that means that you cannot compare 0150 to 1000 because you can't compare milligrams to percentages. You can change milligrams to percentages and visa versa. The conversion table is so large, that First	

	DataBank only offers this by electronic media, not on paper. The SKEY-PS specifies the package quantity and its unit of measure (each, ml, or gram). This field can be combined with all other sub-fields for specific or general searches. The thirty most common package sizes are in the range of 001 - 030. The Unit Dose/Use only has 3 values. This field should be considered an extension of the SKEY-PS, but it could be used as an independent field. The Smart Key data is confidential, whoever wants it will have to buy the info from the 'First Data Bank'. What DHCS can release is just the NDC. The Smart Key is part of First DataBank's drug information system and is composed of eight fields. It is called SKEY for short and it 'leverages existing National Drug Data File (NDDF(TM)) data with two new codified fields resulting in a unique field, initially consisting of seven independent codes: High level therapeutic class, specific therapeutic class code, modified hierarchical ingredient code list sequence number, a new strength code, dosage form code, route of administration code and a new package size code.' But try to get detailed information from their web site and you can't. You need an ID and password to do a search using SMART KEY as of June 2000. The Smart Key 'accommodates both general as well as specific classification of drugs, with ingredient, strength, dosage, route and package size identification.' It is possible to by using the SKEY-HICL (Hierarchical Ingredient Code List) and SKEY-RT (Route of administration) to find all of one kind of product and how it is given by those two codes, such as oral diazepam products. This will find them all without regard to manufacturer, size or dosage form. 'The Smart Key was designed for purchasing agents and for applications requiring formulary definition. Applications used for selecting and stratifying drug products on the basis of product groups, require a great deal of flexibility. For instance, it may be necessary to identify all NDCs (National Drug Codes), with a certain combination of ingredients, dose, route, package size, and in unit dose form. The Smart Key would allow this identification, without having to specify NDCs. From this specific Smart Key definition all current NDCs could then be selected and made part of the request for bid.' The quoted information is from the Smart Key Specification dated April 2, 1993, copyrighted by The Hearst Corporation.
Revisions and History:	**Date** | **Description** For the history of this data element, see Appendix G, First Data Bank Smart Key

113.1 ENHANCED THERAPEUTIC CLASS

COBOL Name:	F35C-ENHANCED-THERAPEUTIC-CLS	
Location in Main Type Segment:	**230-237**	
Definition:	For future use.	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

114.0 MEDICAL SUPPLY INDICATOR

COBOL Name:	F35C-MEDICAL-SUPPLY-IND	
Location in Main Type Segment:	**254-254**	
Definition:	Medical Supply Indicator indicates whether the drug code reported in the Drug Procedure Code field is for a medical supply.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Y = The claim must be a Pharmacy, Medical/Physician or Outpatient claim. Currently, medical supplies are bills using only state drug codes. For a state drug code to be used and to be valid, the following must apply: 1. The field Drug Procedure Code must contain a state drug code, as follows: 4 bytes of LOW-VALUES (binary zeroes), four bytes (Medi-Cal drug code) with a value of 9900 through 9999, one byte (drug strength) with a value of 'A' through 'Z', two alphanumeric bytes for the drug manufacturer code, 9 bytes of spaces, and 2. The field Drug Procedure Indicator must = '3' N = Not a medical supply, if the claim is a Pharmacy, Medical/Physician or Outpatient claims. Space = Not a Pharmacy, Outpatient, or Medical/Physician claim. See Appendix A, F35C-MEDICAL-SUPPLY-IND-Edit for more information.	
Comments and Special Considerations:		

Revisions and History:	**Date**	**Description**
	Nov 2003	Revised by V1R15

115.0 TOOTH SURFACES

COBOL Name:	F35C-TOOTH-SURFACES	
Location in Main Type Segment:	**255-259**	
Definition:	Tooth Surface Location is a 5-byte area used for denoting tooth surfaces, 1 byte for up to 5 occurrences per procedure code. Each byte indicates a tooth surface location for Dental claims.	
Format Description:	Data Type:	Character
	Display Length:	5
	Storage Length:	5
	Picture Clause:	X(05)
Allowed Values:	There are five 1-byte using the code as follow: B = Buccal Cheek side D = Distal Side of the tooth facing the back of the mouth* F = Facial Top and bottom 8 teeth you can See when you smile L = Lingual Tongue side M = Mesial Side of the tooth facing the front of the mouth* I = Incisal The cutting edge of the incisor teeth O = Occlusal The grinding or biting surface G = Gingival At the gum line *The distal surface of the tooth face, the mesial surface of the next tooth back.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	For the history of this data element, see Appendix G, Tooth Surfaces.	

116.0 BILLED CODE INDICATOR

COBOL Name:	F35C-BILLED-CODE-IND	
Location in Main Type Segment:	**260-260**	
Definition:	Billed Code Indicator provides information about the original contents of the Procedure Code field before any cross-referencing took place. It is populated internally by DHCS.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	N = 'NDC' S = 'Spaces' R = 'Reject' C = 'Compound' A = 'Anti-Cancer' T = 'TAR' M = 'Medi-Cal' J = 'Junk' E = 'Error' D = 'Denied Dental'	
Comments and Special Considerations:	Paid Claims data sources supply a SPACE in this field. This field has always been on the appended 35-file record. Drug claims come in with either an 11-digit NDC or a 5-digit State drug code in the Procedure Code field. ITSD runs all drug claims through a program that looks at the Drug Formulary file and tries to find the corresponding obsolete 5-digit State drug code value for the NDC that was billed. This is because the Procedure Code field in the Long Paid Claims and Short Paid Claims only has room for the 5-digit State drug code. The program also tries to find the corresponding NDC for any 5-digit State drug code that was billed**.** Dental denied claims lines are being sent along with Dental paid claim lines. The 'D' in the indicator field will help identify Dental Denied claim lines so that they aren't counted with the paid claim lines.	
Revisions and History:	**Date**	**Description**
	6/2012	Added code D.

117.0 DETAIL FFP INDICATOR

COBOL Name:	F35C-DET-FFP-IND	
Location in Main Type Segment:	**261-261**	
Definition:	Detailed FFP (Federal Financial Participation) Indicator currently used only on FPACT claims from EDS to indicate the level of Medicaid Federal Financial Participation, if any, that the state may claim.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Space = Detail FFP not set 1 = Detail FFP FMAP Rate 2 = Detail FFP 90 percent 3 = Detail FFP non FFP	
Comments and Special Considerations:	The value depends on the claim type. For LTC, XOVER, and VSN claims, the value is a space. See Appendix A, F35C-DET-FFP-IND-Edit for more information.	
Revisions and History:	**Date**	**Description**

118.0 REVENUE TYPE CODE

COBOL Name:	F35C-REVENUE-TYPE-CODE	
Location in Main Type Segment:	**262-263**	
Definition:	The Revenue Type Code is used to vary the revenue code price.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	**Revenue Type Codes** NC Non Contract **Note:** Includes Sick Baby not associated with delivery – Non Contract CM Contract – Per Diem **Note:** Includes Sick Baby not associated with delivery – Contract CD Contract – Per Discharge OB Contract – OB Per Discharge All Inclusive BT Bone Marrow Transplant HT Heart Transplant HL Heart-Lung Transplant HS Hospice KT Kidney Transplant LS Liver, Small Bowel or Combined Liver-Small Bowel Transplant LU Lung Transplant PT Pancreas Transplant KP Kidney Pancreas Transplant EC ECMO IN INO SN Sick Baby – Mom discharged – Contract SD Sick Baby associated with delivery – Mom discharged - Contract SM Sick Baby associated with delivery – Non Contract PA Psych Adolescent PB Psych Adult See Appendix A, F35C-REVENUE-TYPE-CODE-Edit for more information.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	6/1/2007	HS put in, SE taken out.

119.0 REVENUE CODE

COBOL Name:	F35C-REVENUE-CODE	
Location in Main Type Segment:	**264-267**	
Definition:	This is the national revenue code that the provider bills on an Inpatient claim. On the 35 file, this is also the LTC revenue code.	
Format Description:	Data Type:	Character
	Display Length:	4
	Storage Length:	4
	Picture Clause:	X(04)
Allowed Values:	Prior to HIPAA, the system accepted all numeric values greater than 0. After SDN 2071 (HIPAA Code Sets), there is only a specific set of revenue codes that are considered valid. '0111' THRU '0114' '0117' THRU '0119' '0121' THRU '0124' '0127' THRU '0129' '0131' THRU '0134' '0137' THRU '0139' '0151' THRU '0154' '0157' THRU '0159' '0169' '0170' THRU '0174' '0200' THRU '0204' '0206' THRU '0212' '0214' '0219' '0790' '1170' '1172' THRU '1174'. For LTC claims, the system only accepts numeric values. If not numeric or less than zero, the system moves zeroes to the field. The LTC claim, however, does not use this field in pricing. It uses instead the LTC Accommodation Code: F35C-ACCOMMODATION-CODE.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

120.0 DUR ALERT DATA

COBOL Name:	F35C-DUR-ALERT-DATA	
Location in Main Type Segment:	**268-273**	
Definition:	DUR Alert Data indicates Drug Utilization and Review alerts	
Format Description:	Data Type:	Character
	Display Length:	6
	Storage Length:	6
	Picture Clause:	X(06)
Allowed Values:	Alphanumeric (3 2-byte fields).	
Comments and Special Considerations:	There are three 2-byte sub-fields in the following order, taken from the NCPDP Data Dictionary 5.1: DUR Conflict Alert (Reason for Service Code): Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service: AD = Additional Drug Needed AN = Prescription Authentication AR = Adverse Drug Reaction AT = Additive Toxicity CD = Chronic Disease Management CH = Call Help Desk CS = Patient Complaint/Symptom DA = Drug-Allergy DC = Drug-Disease (Inferred) DD = Drug-Drug Interaction DF = Drug-Food interaction DI = Drug Incompatibility DL = Drug-Lab Conflict DM = Apparent Drug Misuse DS = Tobacco Use ED = Patient Education/Instruction ER = Overuse EX = Excessive Quantity HD = High Dose IC = Iatrogenic Condition ID = Ingredient Duplication LD = Low Dose LK = Lock In Recipient LR = Underuse MC = Drug-Disease (Reported) MN = Insufficient Duration MS = Missing Information/Clarification MX = Excessive Duration NA = Drug Not Available NC = Non-covered Drug Purchase ND = New Disease/Diagnosis NF = Non-Formulary Drug NN = Unnecessary Drug NP = New Patient Processing NR = Lactation/Nursing Interaction	

	NS = Insufficient Quantity OH = Alcohol Conflict PA = Drug-Age PC = Patient Question/Concern PG = Drug-Pregnancy PH = Preventive Health Care PN = Prescriber Consultation PP = Plan Protocol PR = Prior Adverse Reaction PS = Product Selection Opportunity RE = Suspected Environmental Risk RF = Health Provider Referral SC = Suboptimal Compliance SD = Suboptimal Drug/Indication SE = Side Effect SF = Suboptimal Dosage Form SR = Suboptimal Regimen SX = Drug-Gender TD = Therapeutic TN = Laboratory Test Needed TP = Payer/Processor Question DUR Intervention Alert (Professional Service Code): Code identifying the pharmacist intervention when a conflict code has been identified or service has been rendered: 00 = No intervention AS = Patient assessment CC = Coordination of care DE = Dosing evaluation/determination FE = Formulary enforcement GP = Generic product selection MA = Medication administration M0 = Prescriber consulted MR = Medication review PE = Patient education/instruction PH = Patient medication history PM = Patient monitoring P0 = Patient consulted PT = Perform laboratory test R0 = Pharmacist consulted other source RT = Recommend laboratory test SC = Self-care consultation SW = Literature search/review TC = Payer/processor consulted TH = Therapeutic product interchange DUR Outcome Alert (Result of Service Code): Action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service: 00 = Not Specified 1A = Filled As Is, False Positive 1B = Filled Prescription As Is 1C = Filled, With Different Dose 1D = Filled, With Different Directions 1E = Filled, With Different Drug 1F = Filled, With Different Quantity 1G = Filled, With Prescriber Approval

<table>
<tr><td></td><td colspan="2">1H = Brand-to-Generic Change
1J = Rx-to-OTC Change
1K = Filled with Different Dosage Form
2A = Prescription Not Filled
2B = Not Filled, Directions Clarified
3A = Recommendation Accepted
3B = Recommendation Not Accepted
3C = Discontinued Drug
3D = Regimen Changed
3E = Therapy Changed
3F = Therapy Changed-cost increased acknowledged
3G = Drug Therapy Unchanged
3H = Follow -Up/Report
3J = Patient Referral
3K = Instructions Understood
3M = Compliance Aid Provided
3N = Medication Administered</td></tr>
<tr><td rowspan="4">Revisions and History:</td><td>Date</td><td>Description</td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2"></td></tr>
</table>

120.1 DUR CONFLICT ALERT

COBOL Name:	F35C-DUR-CONFLICT-ALERT	
Location in Main Type Segment:	**268-269**	
Definition:	DUR Conflict Alert identifies the type of utilization conflict detected or the reason for the pharmacist's professional service.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	The following codes are from NCPDP Data Dictionary 5.1. DA Drug-Allergy Conflict AT Additive Toxicity PG Drug-Pregnancy Conflict ID Ingredient Duplication MC Drug-Disease Conflict (Reported Diagnosis from Medical Claim) PA Drug-Age Alert (Pediatric or Geriatric) DD Drug-Drug Interaction HD High Dose TD Therapeutic Duplication LD Low Dose ER Over-utilization (Early Refill) MX Incorrect Duration of Therapy LR Under-utilization (Late Refill) SX Drug-Gender Conflict However, the following values are available under the NCPDP Data Dictionary 5.1, and may appear as conflict codes. AD Additional Drug Needed AN Prescription Authentication AR Adverse Drug Reaction AT Additive Toxicity CD Chronic Disease Management CH Call Help Desk CS Patient Complaint/ Symptom DA Drug- Allergy DC Drug- Disease (Inferred) DD Drug- Drug Interaction DF Drug- Food interaction DI Drug Incompatibility DL Drug- Lab Conflict DM Apparent Drug Misuse DS Tobacco Use ED Patient Education/ Instruction ER Overuse EX Excessive Quantity HD High Dose IC Iatrogenic Condition ID Ingredient Duplication LD Low Dose	

	LK Lock In Recipient LR Under-use MC Drug- Disease (Reported) MN Insufficient Duration MS Missing Information/ Clarification MX Excessive Duration NA Drug Not Available NC Non- covered Drug Purchase ND New Disease/ Diagnosis NF Non- Formulary Drug NN Unnecessary Drug NP New Patient Processing NR Lactation/ Nursing Interaction NS Insufficient Quantity OH Alcohol Conflict PA Drug- Age PC Patient Question/ Concern PG Drug- Pregnancy PH Preventive Health Care PN Prescriber Consultation PP Plan Protocol PR Prior Adverse Reaction PS Product Selection Opportunity RE Suspected Environmental Risk RF Health Provider Referral SC Suboptimal Compliance SD Suboptimal Drug/ Indication SE Side Effect SF Suboptimal Dosage Form SR Suboptimal Regimen SX Drug- Gender TD Therapeutic TN Laboratory Test Needed TP Payer/ Processor Question
Comments and Special Considerations:	See Appendix A, F35C-DUR-CONFLICT-ALERT-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 439-E4, 'Reason for Service Code'
Revisions and History:	**Date** | **Description** |

120.2 DUR INTERVENTION ALERT

COBOL Name:	F35C-DUR-INTERVENTION-ALERT	
Location in Main Type Segment:	**270-271**	
Definition:	DUR Intervention Alert identifies the pharmacist intervention when a conflict code has been identified or service has been rendered.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Medi-Cal requests that only the following codes be used: M0 (M zero) Prescriber Consulted P0 (P zero) Patient Consulted R0 (R zero) Pharmacist Consulted Other Source However, the following values are available under the NCPDP Data Dictionary 5.1, and may appear as intervention codes: 00 No intervention AS Patient assessment CC Coordination of care DE Dosing evaluation/ determination FE Formulary enforcement GP Generic product selection MA Medication administration M0 Prescriber consulted MR Medication review PE Patient education/ instruction PH Patient medication history PM Patient monitoring P0 Patient consulted PT Perform laboratory test R0 Pharmacist consulted other source RT Recommend laboratory test SC Self- care consultation SW Literature search/ review TC Payer/ processor consulted TH Therapeutic product interchange	
Comments and Special Considerations:	See Appendix A, F35C-DUR-INTERVENTION-ALERT-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 440-E5, 'Professional Service Code'	
Revisions and History:	**Date**	**Description**

120.3 DUR OUTCOME ALERT

COBOL Name:	F35C-DUR-OUTCOME-ALERT	
Location in Main Type Segment:	**272-273**	
Definition:	DUR Outcome Alert identifies action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	The following codes are from NCPDP Data Dictionary 5.1: <u>Outcome Code</u> 1A Filled, false positive 1F Filled with different quantity 1B Filled prescription as is 1G Filled with prescriber approval 1C Filled with different dose 2A Prescription not filled 1D Filled with different directions 1E Filled with different drug 2B Prescription not filled – directions clarified However, the following values are available under the NCPDP Data Dictionary 5.1, and may appear as intervention codes: <u>Result of Service Code</u> 00 Not specified 1A Filled As Is, False Positive 1B Filled Prescription As Is 1C Filled, With Different Dose 1D Filled, With Different Directions 1E Filled, With Different Drug 1F Filled, With Different Quantity 1G Filled, With Prescriber Approval 1H Brand- to- Generic Change 1J Rx- to- OTC Change 1K Filled with Different Dosage Form 2A Prescription Not Filled 2B Not Filled, Directions Clarified 3A Recommendation Accepted 3B Recommendation Not Accepted 3C Discontinued Drug 3D Regimen Changed 3E Therapy Changed 3F Therapy Changed- cost increased acknowledged 3G Drug Therapy Unchanged 3H Follow- Up/ Report 3J Patient Referral 3K Instructions Understood 3M Compliance Aid Provided 3N Medication Administered	

Comments and Special Considerations:	See Appendix A, F35C-DUR-OUTCOME-ALERT-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 441-E6, 'Result of Service Code'	
Revisions and History:	**Date**	**Description**

121.0 COMPOUND CODE

COBOL Name:	F35C-COMPOUND-CODE	
Location in Main Type Segment:	**274-274**	
Definition:	Indicates whether a drug claim is for a compound drug.	
Format Description:	Data type:	Character
	Display length:	1
	Storage length:	1
	Picture clause:	X(01)
Allowed Values:	Taken from the NCPDP Data Dictionary 5.1: Space = Not a drug claim 0 = Not specified 1 = Not a compound 2 = Compound	
Comments and Special Considerations:	This field alone determines whether or not the claim is a compound drug claim. If the claim type is '3' (pharmacy): ▪ For a compound drug, F35C-COMPOUND-CODE must be '2'. ▪ If not for a compound drug, F35C-COMPOUND-CODE must be '0' or '1'. If the claim type is not '3' (pharmacy), then F35C-COMPOUND-CODE must be space. See Appendix A, F35C-COMPOUND-CODE-Edit for more information. Note: With reference to County Organized Health System pharmacy claims reporting, the Corresponding NCPDP – Post Adjudication Standard Data Element is: 406-D6, 'Compound Code' If compound drugs are reported with multi-ingredient processing, the Claim Segment will contain '0' for field 407-D7 (Product/Service ID) and '2' for field 406-D6 (Compound Code). The Compound Segment will contain each NDC and quantity used in preparing the compound. If compound drugs are not reported with multi-ingredient processing, the Compound Segment is not used and the NDC of the most expensive ingredient will be in field 407-D7 (Product/Service ID), '2' in field 406-D6 (Compound Code).	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

122.0 COMPOUND DRUG ATTACHMENT

COBOL Name:	F35C-COMPOUND-DRUG-ATTACHMENT	
Location in Main Type Segment:	**275-275**	
Definition:	Identifies whether or not a compound drug attachment listing a compound drug's ingredients is attached to the drug claim form.	
Format Description:	Data type:	Numeric
	Display length:	1
	Storage length:	1
	Picture clause:	9(01)
Allowed Values:	0 = No 'C' segment present OR not a compound drug 1 = Compound drug claim, 'C' segments are present	
Comments and Special Considerations:	If the field F35C Compound Code is a '2', the field Compound Drug Attachment may be 1 or 0. ▪ If 0 then there can be no 'C' segments attached. ▪ If 1 then there must be at least one 'C' segment attached. If the field F35C Compound Code is NOT a '2', ▪ The Compound Drug Attachment field must be 0. ▪ There can be no 'C' segments attached. A compound drug claim record (effective with SDN6043) normally has one, and only one, main - type 'M' - segment as the first detail segment, followed by 0 to 40 compound drug segments. Claims processed by EDS will have 0 to 25 segments. Other data sources may provide up to 40. A compound drug record may have 0 compound drug segments, but must always have at least one main segment. A compound drug claim record cannot have a segment count of zero, with no detail segments, as the information that the drug is a compound is located on the main segment. Without a main segment it is impossible to know a claim is for a compound drug. A drug claim record may have multiple main type segments that are flagged as ‘compound drug’, but if there are multiple main type segments there can be no compound drug segments. In that case the value of Compound Drug Attachment in each of the main segments must be 0. That condition could occur on drug claims prior to implementation of SDN 02024 on 9/22/2003, or on drug claims from sources other than EDS, the main Medi-Cal Fiscal Intermediary. **Other record types:** For non-compound drug claims the value of this field should be zero. For non-drug claims the value of this field should be zero.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

123.0 COMPOUND DRUG NUMBER OF INGREDIENTS

COBOL Name:	F35C-COMPOUND-DRUG-NBR-INGRED	
Location in Main Type Segment:	**276-277**	
Definition:	This field indicates how many type 'C' (compound drug) segments are attached to the header.	
Format Description:	Data type:	Numeric
	Display length:	2
	Storage length:	2
	Picture clause:	9(02)
Allowed Values:	0 – 40.	
Comments and Special Considerations:	0-25: EDS allows maximum of 25 segments (24 if a container count is reported). 0-40: Other data sources may report up to 40 'C' segments. This field does NOT report the actual number of ingredients in the compound drug. That is recorded in the field Compound Actual Number of Ingredients. For an EDS claim, the value of Compound Actual Number of Ingredients and Compound Drug Number of Ingredients must be equal if there are 24 or fewer 'C' segments.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

124.0 CCS GHPP LEGAL COUNTY

COBOL Name:	F35C-CCS-GHPP-LEGAL-COUNTY	
Location in Main Type Segment:	**278-279**	
Definition:	As part of SDN047, each CCS/GHPP claim line may have a TAR (SAR), and each TAR can have a different Legal County. This only affects the EDS and Delta claims.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	The 58 California counties. 59 = Legal county state paid only.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

125.0 CCS GHPP FUNDING CATERGORY

COBOL Name:	F35C-CCS-GHPP-FUNDING-CATERGORY	
Location in Main Type Segment:	**280-280**	
Definition:	As part of SDN047, each CCS/GHPP claim line may have a TAR (SAR), and each TAR can have a different funding category. This only affects the EDS and Delta claims.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	1 = Diagnostic 2 = Treatment 3 = Therapy 5 = HF-Treatment 6 = HF-Therapy	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

126.0 FINANCIAL INDICATOR

COBOL Name:	F35C-FINANCIAL-INDICATOR	
Location in Main Type Segment:	**281-281**	
Definition:	The Financial Indicator idenitifies which financial program the claim is being paid under.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	1 = Medi-Cal 2 = CMSP 3 = Abortion 4 = CCS 5 = GHPP 6 = GHPP 1st prior year 7 = GHPP 2nd prior year A = Healthy Families L = LA County Mental Health M = Caloptima Xover N = Caloptima LTC See Appendix A, F35C-FINANCIAL-INDICATOR-Edit for more information.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

127.0 FUNDING INDICATOR

COBOL Name:	F35C-FUNDING-INDICATOR	
Location in Main Type Segment:	**282-284**	
Definition:	For future use.	
Format Description:	Data Type:	Character
	Display Length:	3
	Storage Length:	3
	Picture Clause:	X(03)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

128.0 DETAIL AID CATEGORY

COBOL Name:	F35C-DET-AID-CATEGORY	
Location in Main Type Segment:	**285-286**	
Definition:	Detail Aid Category refers to the aid code with which claim line was paid.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	For a list of aid codes, visit the MEDS Homepage Web Site at: https://www.ext.dhs.ca.gov/meds_home/0_meds_manual/appendices/Appendix_D_Quick_Ref_Guides/Aid_Code_QRGc.doc See Appendix A, F35C-DET-AID-CODE-Edit for more information.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	6/27/2007	New data element

129.0 MAIN SEGMENT ID NUMBER

COBOL Name:	F35C-MAIN-SEGMENT-ID-NBR-X	
Location in Main Type Segment:	**309-310**	
Definition:		
Format Description:	Data Type:	Numeric
	Display Length:	2
	Storage Length:	2
	Picture Clause:	9(02)
Allowed Values:		
Comments and Special Considerations:	Populated by ITSD	
Revisions and History:	**Date**	**Description**

130.0 SEGMENT TYPE C

COBOL Name:	F35C-SEGMENT-TYPE-C	
Location in Compound Drug Segment:	**001-001**	
Definition:	The segment type must be 'C' for a compound drug segment.	
Format Description:	Data type:	Character
	Display length:	1
	Storage length:	1
	Picture clause:	X(01)
Allowed Values:	Valid value must be ‘C’ for Compound Drug Segment.	
Comments and Special Considerations:	The segment type field indicates whether the segment is a main segment, type 'M' or compound drug segment, type 'C'. There are no other valid values.	
Revisions and History:	**Date**	**Description**

131.0 COMPOUND GENERAL INFORMATION

COBOL Name:	F35C-CMPND-GENERAL-INFO	
Location in Compound Drug Segment:	**002-066**	
Definition:	F35C-CMPND-GENERAL-INFO is a group data element and contains information that applies to the compound drug as a whole. The data in this area is identical on each compound drug segment for the claim.	
Format Description:	Data type:	Varies
	Display length:	65
	Storage length:	65
	Picture clause:	Varies
Allowed Values:	See individual fields below: COMPOUND DOSAGE FORM COMPOUND INCENTIVE AMOUNT COMPOUND FEE COMPOUND INCENTIVE AMOUNT PAID COMPOUND ACTUAL NUMBER OF INGREDIENTS COMPOUND ROUTE OF ADMINISTRATION COMPOUND UNIT FORM INDICATOR COMPOUND CONTAINER COUNT COMPOUND PROCESS APPROVED INGREDIENTS	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

131.1 COMPOUND DOSAGE FORM

COBOL Name:	F35C-CMPND-DOSAGE-FORM	
Location in Compound Drug Segment:	**002-003**	
Definition:	Compound dosage form identifies the type of the complete compound mixture.	
Format Description:	Data type:	Character
	Display length:	2
	Storage length:	2
	Picture clause:	X(02)
Allowed Values:	The following values for the compound dosage form description code are taken from the NCPDP Data Dictionary 5.1: Blank = Not specified 01 = Capsule 02 = Ointment 03 = Cream 04 = Suppository 05 = Powder 06 = Emulsion 07 = Liquid 10 = Tablet 11 = Solution 12 = Suspension 13 = Lotion 14 = Shampoo 15 = Elixir 16 = Syrup 17 = Lozenge 18 = Enema	
Comments and Special Considerations:	For claims submitted to EDS, the claim is rejected if the code is not a valid NCPDP value or if it is blank.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

131.2 COMPOUND INCENTIVE AMOUNT

COBOL Name:	F35C-CMPND-INCENTIVE-AMOUNT	
Location in Compound Drug Segment:	**004-008**	
Definition:	Compound incentive amount identifies the additional incentive amount billed.	
Format Description:	Data type:	Packed
	Display length:	9
	Storage length:	5
	Picture clause:	S9(7)V9(2) COMP-3
Allowed Values:	Numeric. Incentive amount – 99 cents per container	
Comments and Special Considerations:	Currently, Compound Incentive Amount will contain the sterility test fee billed. Compound Incentive Amount field may be zero. If the claim is a negative adjustment, Compound Incentive Amount may be a negative number, otherwise it must be positive or zero.	

Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

131.3 COMPOUND FEE

COBOL Name:	F35C-CMPND-FEE	
Location in Compound Drug Segment:	**009-013**	
Definition:	Compound fee identifies the compounding fee billed by the pharmacist. This is a fee that is paid in addition to the regular dispensing fee.	
Format Description:	Data type:	Packed
	Display length:	9
	Storage length:	5
	Picture clause:	S9(7)V9(2) COMP-3
Allowed Values:	Numeric. Compounding fee – depends on the kind of compound. No set value.	
Comments and Special Considerations:	This field may be zero. If the claim is a negative adjustment this field may be a negative number, otherwise it must be positive or zero.	

Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

131.4 COMPOUND INCENTIVE AMOUNT PAID

COBOL Name:	F35C-CMPND-INCENTIVE-AMOUNT-PD	
Location in Compound Drug Segment:	**014-018**	
Definition:	This field will contain the sterility test fee paid.	
Format Description:	Data type:	Packed
	Display length:	9
	Storage length:	5
	Picture clause:	S9(7)V9(2) COMP-3
Allowed Values:	Numeric (monetary value). Incentive amount paid should not exceed 99 cents per container.	
Comments and Special Considerations:	This field may be zero. If the claim is a negative adjustment this field may be a negative number, otherwise it must be positive or zero.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

131.5 COMPOUND ACTUAL NUMBER OF INGREDIENTS

COBOL Name:	F35C-CMPND-ACTUAL-NBR-INGR	
Location in Compound Drug Segment:	**019-020**	
Definition:	This element gives the actual number of ingredients that were used to create the compound drug.	
Format Description:	Data type:	Numeric
	Display length:	2
	Storage length:	2
	Picture clause:	9(02)
Allowed Values:	Numeric. 0 to 99	
Comments and Special Considerations:	This element indicates the total number of ingredients in the compound, not the number of compound drug segments. F35C-CMPND-ACTUAL-NBR-INGR must be greater than or equal to the value in F35C-COMPOUND-DRUG-NBR-INGRED, the field that does indicate the number of compound drug segments attached. For an EDS claim, the value of F35C-CMPND-ACTUAL-NBR-INGR and F35C-COMPOUND-DRUG-NBR-INGRED must be equal if there are 24 or fewer 'C' segments.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

131.6 COMPOUND ROUTE OF ADMINISTRATION

COBOL Name:	F35C-COMPND-ROUTE-OF-ADMIN	
Location in Compound Drug Segment:	**021-022**	
Definition:	Compound route of administration identifies the route of administration of the complete compound mixture.	
Format Description:	Data type:	Numeric
	Display length:	2
	Storage length:	2
	Picture clause:	9(02)
Allowed Values:	Numeric. 00 = Not specified 01 = Buccal 02 = Dental 03 = Inhalation 04 = Injection 05 = Intraperitoneal 06 = Irrigation 07 = Mouth/throat 08 = Mucous membrane 09 = Nasal 10 = Ophthalmic 11 = Oral 12 = Other/miscellaneous 13 = Otic 14 = Perfusion 15 = Rectal 16 = Sublingual 17 = Topical 18 = Transdermal 19 = Translingual 20 = Urethral 21 = Vaginal 22 = Enteral	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised
	6/27/2007	Current values according to the NCPDP Data Dictionary September, 1999.

131.7 COMPOUND UNIT FORM INDICATOR

COBOL Name:	F35C-CMPND-UNIT-FORM-IND	
Location in Compound Drug Segment:	**023-023**	
Definition:	This field indicates the unit form in which the compound drug is dispensed.	
Format Description:	Data type:	Numeric
	Display length:	1
	Storage length:	1
	Picture clause:	9(01)
Allowed Values:	Numeric. 1 = Each 2 = Grams 3 = Milliliters	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

131.8 COMPOUND CONTAINER COUNT

COBOL Name:	F35C-CMPND-CONTAINER-COUNT	
Location in Compound Drug Segment:	**024-025**	
Definition:	This field indicates the count of the containers used to create the compound drug.	
Format Description:	Data type:	Packed
	Display length:	3
	Storage length:	2
	Picture clause:	S9(03) COMP-3
Allowed Values:	Any numeric value from -999 to +999.	
Comments and Special Considerations:	This field may be zero. If the claim is a negative adjustment this field may be a negative number, otherwise it must be positive or zero.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

131.9 COMPOUND PROCESS APPROVED INGREDIENTS

COBOL Name:	F35C-CMPND-PROCESS-APPRVD-INGR	
Location in Compound Drug Segment:	**026-026**	
Definition:	There is an approved list of ingredients for a particular compound drug and an approved price for the compound drug. More expensive ingredients may be substituted, however they will be reimbursed only for the amount of the approved ingredients. This field is used when the pharmacy wishes to be paid for the standard fee, despite having used some more expensive ingredients.	
Format Description:	Data type:	Character
	Display length:	1
	Storage length:	1
	Picture clause:	X(01)
Allowed Values:	Y = Process claim using standard ingredients / charges. N = Adjudicate the claim using ingredients / charges actually submitted. Space = N/A, not specified. If unapproved ingredients are included in the compound and this field is space, the claim will be rejected.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

132.0 COMPOUND INGREDIENT INFORMATION

COBOL Name:	F35C-CMPND-INGREDIENT-INFO	
Location in Compound Drug Segment:	**067-209**	
Definition:	Compound ingredient info shows information for each specific ingredient in the compound drug.	
Format Description:	Data type:	Varies
	Display length:	143
	Storage length:	143
	Picture clause:	Varies
Allowed Values:	This is a group element that contains information specific to each reported ingredient in the compound drug. It contains the following fields: COMPOUND INGREDIENT AREA COMPOUND INGREDIENT NATIONAL DRUG CODE COMPOUND INGREDIENT UPN COMPOUND INGREDIENT PRODUCT ID COMPOUND INGREDIENT PRODUCT ID QUALIFIER COMPOUND INGREDIENT BASIS OF COST DETERMINATION COMPOUND INGREDIENT DISPENSING FEE CODE COMPOUND INGREDIENT METRIC QUANTITY COMPOUND INGREDIENT BILLED AMOUNT COMPOUND INGREDIENT ALLOWED AMOUNT COMPOUND INGREDIENT REIMBURSE AMOUNT COMPOUND SMART KEY COMPOUND INGREDIENT CUTBACK REASON	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

132.1 COMPOUND INGREDIENT AREA

COBOL Name:	F35C-CMPND-INGREDIENT-AREA	
Location in Compound Drug Segment:	**067-106**	
Definition:	This field contains information on the Compund Ingredient NDC, the Compound Ingredient UPN, or the Compound Ingredient Product ID.	
Format Description:	Data type:	Character
	Display length:	40
	Storage length:	40
	Picture clause:	X(40)
Allowed Values:	Valid NDC codes, valid UPNs, or valid Product IDs. COMPOUND INGREDIENT NATIONAL DRUG CODE COMPOUND INGREDIENT UPN COMPOUND INGREDIENT PRODUCT ID	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

132.2 COMPOUND INGREDIENT NATIONAL DRUG CODE

COBOL Name:	F35C-CMPND-INGR-NDC	
Location in Compound Drug Segment:	**067-077**	
Definition:	National Drug Code of the compound drug ingredient.	
Format Description:	Data type:	Character
	Display length:	11
	Storage length:	11
	Picture clause:	X(11)
Allowed Values:	Valid NDC codes	
Comments and Special Considerations:	This field contains the NDC for the ingredient only when the field F35C-CMPND-INGR-PROD-ID-QUAL = '03' Please refer to U.S. Food and Drug Administration web site http://www.fda.gov/cder/ndc/ for the National Drug Code directory.	

Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

132.3 COMPOUND INGREDIENT UPN

COBOL Name:	F35C-CMPND-INGR-UPN	
Location in Compound Drug Segment:	**067-085**	
Definition:	UPN codes are used to bill medical supply claims with either an NDC, UPC, or HIBCC code. The format varies per code source.	
Format Description:	Data type:	Character
	Display length:	19
	Storage length:	19
	Picture clause:	X(19)
Allowed Values:	Based on NDC, UPC, or HIBCC published code values. Alphanumeric up to 19 digits.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

132.4 COMPOUND INGREDIENT PRODUCT ID

COBOL Name:	F35C-CMPND-INGR-PRODUCT-ID	
Location in Compound Drug Segment:	**067-086**	
Definition:	Compound ingredient product id identifies the ingredient used in a compound.	
Format Description:	Data type:	Character
	Display length:	20
	Storage length:	20
	Picture clause:	X(20)
Allowed Values:	May have a product ID number or free-form text up to 20 characters long.	
Comments and Special Considerations:	This field contains the product ID information for an ingredient only when the field Compound Ingredient Product ID Qualifier is NOT = '03'. This field may contain free-form text information such as 'egg white' or water.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

132.5 COMPOUND INGREDIENT PRODUCT ID QUALIFIER

COBOL Name:	F35C-CMPND-INGR-PROD-ID-QUAL	
Location in Compound Drug Segment:	**117-118**	
Definition:	This field identifies the type of code used in data element Compound Ingredient Product ID.	
Format Description:	Data type:	Character
	Display length:	2
	Storage length:	2
	Picture clause:	X(02)
Allowed Values:	Space Not Specified 00 Not Specified 01 Universal Product Code (UPC) 02 Health Related Item (HRI) 03 National Drug Code (NDC) 04 Universal Product Number (UPN) 05 Department of Defense (DOD) 06 Drug Use Review/ Professional Pharmacy Service (DUR/PPS) 07 Common Procedure Terminology (CPT4) 08 Common Procedure Terminology (CPT5) 09 Health Care Financing Administration Common Procedural Coding System (HCPCS) 10 Pharmacy Practice Activity Classification (PPAC) 12 National Pharmaceutical Product Interface Code (NAPPI) 12 International Article Numbering System (EAN) 13 Drug Identification Number (DIN) 100 Other	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

132.6 COMPOUND INGREDIENT BASIS OF COST DETERMINATION

COBOL Name:	F35C-CMPND-INGR-BASIS-OF-COST	
Location in Compound Drug Segment:	**119-120**	
Definition:	Compound ingredient basis of cost indicates the basis used to compute the cost (i.e. whether not disproportionate share/public health service was present).	
Format Description:	Data type:	Character
	Display length:	2
	Storage length:	2
	Picture clause:	X(02)
Allowed Values:	Taken from the NCPDP Data Dictionary 5.1, 490-UE, Compound Ingredient Basis Of Cost Determination: Blank = Not Specified 01 = AWP (Average Wholesale Price) 02 = Local Wholesaler 03 = Direct 04 = EAC (Estimated Acquisition Cost) 05 = Acquisition 06 = MAC (Maximum Allowable Cost) 07 = Usual & Customary 09 = Other (Indicates Disproportionate Share / Public Health Service)	
Comments and Special Considerations:	Data is received under the NCPDP Data Dictionary 5.1 transaction, using field 423-DN 'Basis of Cost Determination'.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

132.7 COMPOUND INGREDIENT DISPENSING FEE CODE

COBOL Name:	F35C-CMPND-INGR-DISP-FEE-CODE	
Location in Compound Drug Segment:	**121-121**	
Definition:	Compound ingredient dispense fee code indicates whether ingredient is a medical supply.	
Format Description:	Data type:	Character
	Display length:	1
	Storage length:	1
	Picture clause:	X(01)
Allowed Values:	'I' or 'M' = medical supply 'A' through 'H' not a medical supply All other values are invalid.	
Comments and Special Considerations:	EDS will not pay for a medical supply billed as a compound drug ingredient. The Dispensing Fee Code on the Formulary File indicates whether an NDC code is for a drug or medical supply. The field will be checked during pricing, and claims with medical supplies will be denied unless billed with the Process for Approved Ingredients field set to Y, in which case the ingredient will be priced at zero. An EDS compound drug paid claim could have an 'I' or an 'M' in this field, but only if the Process for Approved Ingredients field is set to Y.	
Revisions and History:	**Date**	**Description**

132.8 COMPOUND INGREDIENT METRIC QUANTITY

COBOL Name:	F35C-CMPND-INGR-METRIC-QTY	
Location in Compound Drug Segment:	**122-127**	
Definition:	Compound ingredient metric quantity expresses the amount in metric decimal units of the product included in the compound mixture.	
Format Description:	Data type:	Packed
	Display length:	11
	Storage length:	6
	Picture clause:	S9(8)V9(3) COMP-3
Allowed Values:	Numeric. Ingredient metric quantity – varies from NDC to NDC. Maximum for each NDC is found on the Formulary File, and can be overridden by a TAR.	
Comments and Special Considerations:	This field may be zero. If the claim is a negative adjustment this field may be a negative number, otherwise it must be positive or zero.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

132.9 COMPOUND INGREDIENT BILLED AMOUNT

COBOL Name:	F35C-CMPND-INGR-BILLED-AMOUNT	
Location in Compound Drug Segment:	**128-132**	
Definition:	Compound ingredient billed amount identifies the ingredient cost for the metric decimal quantity of the product in the compound mixture.	
Format Description:	Data type:	Packed
	Display length:	9
	Storage length:	5
	Picture clause:	S9(7)V9(2) COMP-3
Allowed Values:	Numeric (monetary value).	
Comments and Special Considerations:	This field may be zero. If the claim is a negative adjustment this field may be a negative number, otherwise it must be positive or zero.	
Revisions and History:	**Date**	**Description**

132.10 COMPOUND INGREDIENT ALLOWED AMOUNT

COBOL Name:	F35C-CMPND-INGR-ALLOWED-AMOUNT	
Location in Compound Drug Segment:	**133-137**	
Definition:	Compound ingredient allowed amount identifies the Medi-Cal allowed amount for the metric decimal quantity of the product in the compound mixture.	
Format Description:	Data type:	Packed
	Display length:	9
	Storage length:	5
	Picture clause:	S9(7)V9(2) COMP-3
Allowed Values:	Numeric (monetary value).	
Comments and Special Considerations:	This field may be zero. If the claim is a negative adjustment this field may be a negative number, otherwise it must be positive or zero.	

Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

132.11 COMPOUND INGREDIENT REIMBURSE AMOUNT

COBOL Name:	F35C-CMPND-INGR-REIMBURSE-AMT	
Location in Compound Drug Segment:	**138-142**	
Definition:	Compound ingredient reimburse amount identifies the Medi-Cal reimbursement amount for the metric decimal quantity of the product in the compound mixture.	
Format Description:	Data type:	Packed
	Display length:	9
	Storage length:	5
	Picture clause:	S9(7)V9(2) COMP-3
Allowed Values:	Numeric (monetary value).	
Comments and Special Considerations:	This field may be zero. If the claim is a negative adjustment this field may be a negative number, otherwise it must be positive or zero.	

Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

132.12 COMPOUND SMART KEY

COBOL Name:	F35C-CMPND-INGR-SMART-KEY	
Location in Compound Drug Segment:	**143-166**	
Definition:	First databank smart key describes the specifics of a drug. It is used for both NDC and state drug codes.	
Format Description:	Data type:	Character
	Display length:	24
	Storage length:	24
	Picture clause:	X(24)

Allowed Values:

For Claims other than EDS, this field should be all spaces.

For EDS claims the following are the valid values.

Fields	Bytes
F35C-CMPND-INGR-SMART-KEY-GTC - dosage form (dose), e.g. 500 = capsule	2
F35C-CMPND-INGR-SMART-KEY-STC - DRUG STRENGTH (STR); e.g., 0600 = 250mg	4
F35C-CMPND-INGR-SMART-KEY-HICL - generic name/hierarchical ingredient code list (HICL) identifies the specific generic entity; e.g., 04003 = Tetracycline HCL	5
F35C-CMPND-INGR-SMART-KEY-STR - generic therapeutic class (GTC) broad classification; e.g., 20 = anti-infective	4
F35C-CMPND-INGR-SMART-KEY-DOSE - package size (PS); e.g., 008 = 100each	3
F35C-CMPND-INGR-SMART-KEY-RT - route of administration (RT); e.g., 01 = oral	2
F35C-CMPND-INGR-SMART-KEY-PS - specific therapeutic class (STC) specific classification; e.g., 0478 = tetracycline	3
F35C-CMPND-INGR-SMART-KEY-UDUU - unit dose/unit of use (UDUU) identifies special packaging; 0 = doesn't have unit dose or use 1 = unit dose 2 = unit of use	1

Comments and Special Considerations:	See SMART-KEY for the definition. Compound Smart Key is specific to the individual ingredient.	
Revisions and History:	Nov 2003	Revised

132.13 COMPOUND INGREDIENT CUTBACK REASON

COBOL Name:	F35C-CMPND-INGR-CUTBACK-REASON	
Location in Compound Drug Segment:	**167-169**	
Definition:	If the amount paid for an ingredient is less than the amount billed, then this field contains a code identifying the reason for the change.	
Format Description:	Data type:	Character
	Display length:	3
	Storage length:	3
	Picture clause:	X(03)
Allowed Values:	700 to 999.	
Comments and Special Considerations:		
Revisions and History:	Nov 2003	Revised

133.0 COMPOUND SEGMENT ID NUMBER

COBOL Name:	F35C-CMPND-SEGMENT-ID-NBR-X	
Location in Compound Drug Segment:	**309-310**	
Definition:	This number identifies the compound segment within the claim. In combination with the RECORD-ID-NUMBER this is a unique key for the segment. This is used by MIS/DSS to facilitate analysis and maintenance.	
Format Description:	Data type:	Numeric
	Display length:	2
	Storage length:	2
	Picture clause:	9(02)
Allowed Values:	02 - 26 for EDS claims 02 - 41 for non-EDS The main segment will always be segment number 1 on a compound drug claim (see Compound Drug Attachment for details).	
Comments and Special Considerations:	This field is populated by ITSD. All other sources should report spaces in this field.	
Revisions and History:	Nov 2003	Revised

APPENDICES

APPENDIX A. 35-FILE EDITS

01	F35C-PAID-CLAIM-RECORD	No Edit	
05	F35C-HEADER	No Edit	
10	F35C-SEGMENT-CNT	MUST BE >= 0 AND <= 99 … For compound drug claim it must be > 0 (always one 'MAIN' segment with compound drug claims)	PIC S9(04) BINARY
10	F35C-PLAN-CODE	MUST BE VALID FOR THE SUBMITTER. 00 = DELTA DENTAL 01= DSS PCSP; DDS WAIVER; DDS TCM; MEDI-CAL TCM 02 = ENCOUNTER DATA FROM MANAGED CARE PLANS 04 = COHS 05 = CHDP 06 = STATE HOSPITALS / STATE DEVELOPMENTAL CTRS 08 = SHORT-DOYLE/MEDI-CAL 09 = EDS	PIC X(02)
10	F35C-CLAIM-TYPE	MUST BE VALID FOR PLAN CODE. PC DHS CT 00 5 (DENTAL) 01 1 (OUTPATIENT) 02 1-5 (VARIOUS) 04,09 1-4 (VARIOUS) 05 6 (CHDP) 06 2 (INPATIENT) 08 1-2 (OUTPAT, INPAT) IF PLAN CODE = 02, 04 or 09, MUST BE VALID FOR FI CT. FI CT DHS CT 01 3 (DRUG) 02,03 2 (INPATIENT) 04 1 (OUTPATIENT) 05,07 4 (MEDICAL)	PIC X(01)
10	F35C-CCN	MUST BE NUMERIC. MUST BE VALID FORMAT BREAK OUT THE JULIAN DATES AND COUNTY CODE PORTIONS TO EDIT THE FORMAT. Plan Code ICN FORMAT 00 0000YJJJ99999 01, 05,08 YYJJJ99999999 02,09 YJJJ999999999	PIC S9(13) COMP-3

		04 AND HCP 506 AND CLAIM TYPE NE '3' YJJJ999999999 04 AND HCP 506 AND CLAIM TYPE EQ '3' 30YYJJJ999999 04 AND HCP 505 (Santa Cruz) YYJJJ99999999 04 AND HCP 508 (Monterey) YYJJJ99999999 04 CCYYJJJ999999 HCP TO CC 502 42 503 41 504 48 507 28 509 57 06 999999999YYMM	
10	F35C-BENE-ID	See below	
15	F35C-BID-COUNTY	See below	
20	F35C-BID-CNTY	MUST BE IN VALID RANGE 01-58. MUST BE VALID FOR COHS HCP CODE. COHS VALID BID PHP COUNTY 502 42 503 41 504 48 505 44 506 30 507 28 508 27 509 57	PIC 9(02)
15	F35C-BID-AID-CODE	MUST BE IN VALID RANGE PER LOOKUP TABLE in he.copylibm.cobol(aidcodpc), 88 level valid-aid	PIC X(02)
20	F35C-BID-CASE-NUMBER	IF DIGIT 1 = '9' AND AID CODE IS 10, 20, OR 60, THEN DIGITS 2-10 SHOULD BE NUMERIC (SSN). IF DIGIT 1 = 'M' AND DIGIT 10 = 'P', THEN DIGITS 2-9 SHOULD BE NUMERIC AND DIGIT 2 SHOULD = '8' OR '9' (PSEUDO SSN). IF DIGIT 1 = 'M' AND DIGIT 10 NOT = 'P', THEN DIGITS 2-10 SHOULD BE NUMERIC (SSN). IF DIGIT 1 = 'C', THEN DIGITS 2 THROUGH 9 SHOULD BE NUMERIC AND DIGIT 10 SHOULD BE 'A', 'C' THROUGH 'H', 'M', 'N', OR 'S' THROUGH 'W' (CIN). IF DIGIT 1 NOT = '9', 'M', OR 'C', THEN DIGITS 2-7 SHOULD NOT CONTAIN SPACES (CASE NUMBER). ALSO CHECK FBU AND PERSON NUMBER FOR THIS PATH.	PIC X(07)
20	F35C-BID-FBU	MUST NOT CONTAIN ANY SPACES.	PIC X(01)
20	F35C-BID-PERSON-NUMBER	MUST NOT CONTAIN ANY SPACES.	PIC X(02)
10	F35C-SSN-OR-MEDS-ID	MUST NOT CONTAIN ANY SPACES	

15	F35C-SSN-OR-MEDS-ID-1	No Edit	PIC X(01)
15	F35C-SSN-OR-MEDS-ID-2-8	No Edit	PIC X(07)
15	F35C-SSN-OR-MEDS-ID-9	No Edit	PIC X(01)
10	F35C-BENE-CIN	MAY BE BLANK, BUT IF IT IS NOT BLANK, THEN FIRST 8 BYTES MUST BE NUMERIC AND END WITH ONE OF THE FOLLOWING ALPHAS ('A', 'C' THROUGH 'H', 'M', 'N', OR 'S' THROUGH 'W'. Report the number of claims with a blank Bene-CIN Call the CIN validation module Report the number of claims with a non-blank but invalid CIN. For each field, report number of times claim values or RACE, GENDER and DATE-OF-BIRTH do not match those on MEDS Count the number of times the CIN number on the claim is changed	PIC X(09)
10	F35C-BENE-NAME	MUST NOT CONTAIN ALL SPACES	PIC X(15)
10	F35C-BENE-SEX	MUST CONTAIN VALUES 1 or M for male, 2 or F for female, or space for unknown.	PIC X(01)
10	F35C-BENE-RACE	IF PLAN CODE = 09, IF AID CODE IS 10, 20, OR 60, MAY CONTAIN SPACES. ELSE MUST CONTAIN VALUES 1-9, A, C, H, J, K, M, N, P, R, T, V, Z END-IF END-IF FROM MTR110 IF PLAN-CODE = '6' INSPECT HDR-RACE-CODE CONVERTING '23456E089A' TO '325CJN8888' IF NOT VALID-RACE-CODE MOVE '8' TO HDR-RACE-CODE END-IF END-IF	PIC X(01)
10	F35C-BENE-HIC	No Edit	PIC X(12)
10	F35C-PROVIDER-ZIP-CODE		
15	F35C-PROVIDER-ZIP-5	MUST BE > 00100.	PIC X(05)
15	F35C-PROVIDER-ZIP-4		PIC X(04)

10	F35C-PROVIDER-NUMBER	MUST NOT CONTAIN ALL SPACES	PIC X(10)
10	F35C-BILLING-PROVIDER-TAXONOMY	New Field, Recommended edit: Validate per table of allowed values HIPAA-related edits. Standards to be established when HIPAA is implemented.	PIC X(10)
10	F35C-BILL-PROVIDER-OWNER-NUM	Must be '00' – '99' or spaces.	PIC X(02)
10	F35C-BILL-PROVIDER-LOCATN-NUM	Must be '000' – '999'.	PIC X(03)
10	F35C-PROVIDER-CNTY	MUST BE IN VALID RANGE 01-58 Provider County could be a 99 for out-of -state providers.	PIC 9(02)
10	F35C-PROVIDER-SPECIALTY	IF VENDOR CODE = 20 OR 22, THEN MUST NOT CONTAIN all SPACES OR all ZEROES. from MTR110 IF TRANS-MANDIBULAR-JAW, OR HEALTH-MANPOWER-PILOT, OR IMMIG-REFORM-CONTROL, OR ROOT-CANAL-THERAPY MOVE '99' TO HDR-PROVIDER-SPECIALTY END-IF	PIC X(02)
10	F35C-REIMBURSEMENT-RATE	No Edit	PIC 9(03)
10	F35C-SPECIAL-PROCESSING-TYPE	Must be 'A', 'B', 'C', 'D', 'E', 'F', 'G', 'L', 'M', 'P', 'R', 'S', 'T', 'U', 'W', or ' '.	PIC X(01)
10	F35C-SPECIAL-PROGRAM-TYPE	Must be 'L', 'W', or ' '.	PIC X(01)
10	F35C-COBA-ID	Must be >= SPACES.	PIC X(05)
10	F35C-PAYER-SEQUENCE-CODE	No edit.	PIC X(01)
10	F35C-VENDOR-CODE	IF PLAN CODE NOT = 05 (CHDP), THEN MUST BE VALID PER VALUES IN MTR100, working storage 88 level w-vendor-valid. MUST BE VALID FOR CERTAIN CLAIM TYPES. DHS CT VALID VENDOR 2 (INPAT) 47,50,56,57,60,63,64,80,95. 3 (DRUG) 26 5 (DENT) 27 IF PLAN CODE = 02, 04, OR 09, THEN must be valid for provider type per correlation lookup table in working storage	PIC 9(02)
10	F35C-DISCHARGE-CODE	IF PLAN CODE = 02, 04, OR 09 AND DHS CLAIM TYPE = 2 (INPAT) AND MEDICARE INDICATOR = SPACE, THEN MUST BE IN RANGE 1-9. IF PLAN CODE = 06, THEN MUST BE IN RANGE 0-9	PIC X(01)
10	F35C-SURGERY-CODE	IF PLAN CODE = 02, 04 or 09 AND DHS CLAIM TYPE = 2 (INPAT) AND PRIMARY SURGERY CODE NOT = SPACES OR ZEROES, THEN MUST CONTAIN SPACE OR 'S'	PIC X(01)

10	F35C-MEDICARE-INDICATOR	LTC claims sometimes contain the patient liability amount in the Medicare deductible amount field, so if vendor code = 47 or 80, then skip; else if coinsurance not = 0 or Medicare deductible not = 0, then must = 1. if Medicare indicator = 1, then header OHC indicator should = space.	PIC X(01)
10	F35C-ADMISSION-DATE	MUST BE NUMERIC. LTC CLAIMS DO NOT REQUIRE THE ADMISSION DATE BUT IF IT IS THERE, THE FORMAT SHOULD BE EDITED. IF MEDICARE INDICATOR = SPACE AND PLAN CODE = 02, 04, 06, OR 09 AND DHS CLAIM TYPE = 2 (INPAT), THEN IF VENDOR CODE = 47 OR 80 AND ADMISSION DATE > 0, THEN MUST CONTAIN VALID CC, YY, MM, DD; ELSE IF VENDOR CODE NOT = 47 OR 80, THEN ADMISSION DATE MUST BE > 0 AND MUST CONTAIN VALID CC, YY,MM,DD. Additional instructions: If > end of month of process month/year THEN move zeroes to field and create special error report	PIC X(08)

10	F35C-DISCHARGE-DATE	IF NOT NUMERIC, MOVE ZEROES TO FIELD.
		IF MEDICARE INDICATOR = SPACE, THEN
		IF (PLAN CODE = 06 AND DHS DISCHARGE CODE > 6) OR
		(PLAN CODE = 02, 04 or 09
		AND DHS CLAIM TYPE = 2
		AND DHS DISCHARGE CODE NOT = 6 or 8), THEN
		MUST BE > 0 AND
		MUST BE > ADMISSION DATE AND
		MUST CONTAIN VALID CC, YY,MM,DD AND
		MUST BE < CHECK DATE.
		Additional instructions: If > end of month of process month/year THEN move zeroes to field and create special error report
			PIC X(08)

10	F35C-CHECK-DATE	MUST BE NUMERIC. MUST BE > 0. must contain valid date. AND must be less than or equal to the last day of the processing month	PIC X(08)
10	F35C-ADJUDICATION-DATE	MUST BE NUMERIC. IF PLAN CODE = 02, 04 or 09, THEN MUST BE > 0 AND MUST CONTAIN VALID CC, YY,MM,DD. MUST BE <= CHECK DATE	PIC X(08)
10	F35C-PATIENT-LIABILITY	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0	PIC S9(7)V9(2) COMP-3
10	F35C-CO-INSURANCE-AMOUNT	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0 Report the number of records with an apparently invalid sign (COHS have unique adjustment	PIC S9(7)V9(2) COMP-3

		methods) 5% error on other edits	
10	F35C-OTHER-COVERAGE-AMOUNT	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0	PIC S9(7)V9(2) COMP-3
10	F35C-HDR-MEDI-CAL-AMT-BILLED	IF F35-HDR-MEDI-CAL-AMOUNT-BILLED NOT NUMERIC MOVE 019 TO W-I-ERROR PERFORM ERROR END-IF IF F35-NEGATIVE-ADJUSTMENT AND F35-HDR-MEDI-CAL-AMOUNT-BILLED > ZERO) OR (NOT F35-NEGATIVE-ADJUSTMENT AND F35-HDR-MEDI-CAL-AMOUNT-BILLED < ZERO) MOVE 020 TO W-I-ERROR PERFORM ERROR end-if IF NOT F35-MEDICARE-IND-1 AND F35-ADJUSTMENT-INDICATOR = SPACES AND F35-OTHER-COVERAGE-INDICATOR NOT = '1' AND F35-PATIENT-LIABILITY = ZERO Total the values of all the detail billed fields IF THE TOTAL OF THE DETAIL BILLED VALUES ARE NOT EQUAL TO THE HDR VALUE MOVE 021 TO W-I-ERROR PERFORM ERROR end-if	PIC S9(7)V9(2) COMP-3
10	F35C-HDR-MEDI-CAL-AMOUNT-PAID	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0. AND must = sum of the detail billed amounts when checking if the sum of the detail billed amounts total to the header billed amount, skip the following claims: - crossovers (medicare indicator = 1) - adjustments (adjustment indicator not equal space) - claims with other health coverage (ohc indicator = 1) - claims with patient liab (patient liability not equal zero)	PIC S9(7)V9(2) COMP-3
10	F35C-MEDICARE-DEDUCTION-AMOUNT	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5),	PIC S9(7)V9(2)

		THEN MUST BE <= 0	COMP-3
10	F35C-MEDICARE-DEDUCTION-CODE	MUST CONTAIN SPACE, A, B, OR C	PIC X(01)
10	F35C-FAMILY-PLANNING-CLAIM	No Edit	PIC X(01)
10	F35C-ADJUSTMENT-INDICATOR	MUST CONTAIN SPACE OR BE IN RANGE 1-6. For some COHS data, the Adjustment Indicator may not agree with the positive/negative sign of the counter fields in the detail segments. It should, however, agree with the sign in the header counter fields.	PIC X(01)
10	F35C-DAYS-STAY	IF not numeric -- error IF negative adjustment and > 0 -- error IF not negative adjustment and < 0 -- error IF not F35-MEDICARE-IND-1 and inpatient-claim LOOP FOR EACH SEGMENT IF numeric IF vendor code = '50' OR '60' OR '63' IF procedure code BED-CODES ADD F35-UNITS (SEG) TO A-UNITS IF vendor = '47' OR '80' ADD F35-UNITS (SEG) TO A-UNITS End loop IF F35-DAYS-STAY NOT = A-UNITS -- error IF DRUG CLAIM THEN A-UNITS CANNOT BE = ZERO IF DRUG CLAIM COUNT NUMBER > 0 BUT LESS THAN 1 IF THE TOTAL NUMBER OF DRUG CLAIMS >0 BUT < 1 UNIT IS GREATER THAN 5% OF TOTAL DRUG CLAIMS ERROR IF THE TOTAL NUMBER > 0 BUT < 1 UNIT IS GREATER THAN 10% OF TOTAL DRUG CLAIMS SEVERE ERROR	PIC S9(3) COMP-3
10	F35C-ADJUSTMENT-CCN	MUST BE NUMERIC. IF ADJUSTMENT INDICATOR NOT = SPACE OR 6, THEN MUST BE > 0 AND FORMAT MUST BE THE SAME AS NOTED ABOVE FOR ICN/CCN	PIC S9(13) COMP-3
10	F35C-HDR-FROM-DATE-OF-SERVICE	MUST BE NUMERIC. MUST BE > 0. MUST CONTAIN VALID CC, YY,MM,DD AND MUST BE < CHECK DATE. MUST BE <= HEADER TO-DOS	PIC X(08)

10	F35C-HDR-TO-DATE-OF-SERVICE	MUST BE NUMERIC. MUST BE > 0. MUST CONTAIN VALID CC, YY,MM,DD AND MUST BE < CHECK DATE.	PIC X(08)
10	F35C-AID-CATEGORY	Aid-Category should have the same edit as the Bene ID Aid Code.	PIC X(02)
10	F35C-FFP-IND	No Edit.	PIC X(01)
10	F35C-CROSSOVER-STATUS-CODE	Valid is 1, 2, 3, or space	PIC X(01)
10	F35C-OTHER-COVERAGE-INDICATOR	IF HEADER OTHER COVERAGE AMOUNT NOT = 0, THEN MUST = 1; ELSE MUST = SPACE.	PIC X(01)
10	F35C-BIRTHDATE	MUST BE NUMERIC. MUST BE > 0. MUST CONTAIN VALID CC, YY,MM,DD AND MUST BE < CHECK DATE	PIC X(08)
10	F35C-CCS-GHPP-INDICATOR	MUST BE '1' OR SPACE	PIC X(01)
10	F35C-PROVIDER-NAME	MUST NOT CONTAIN ALL SPACES.	PIC X(28)
10	F35C-MINOR-CONSENT-SERVICE	No Edit	PIC X(02)
10	F35C-RESTRICTED-SERVICE	No Edit	PIC X(02)
10	F35C-FI-CLAIM-TYPE	IF PLAN CODE = 02, 04 or 09, THEN MUST BE IN RANGE 01-05 OR 07	PIC X(02)
10	F35C-HEALTH-PLAN-CODE	See below	

15	F35C-PHP-CODE	IF PLAN CODE = 02 OR 04, THEN
		MUST NOT CONTAIN SPACES OR ALL ZEROES.
		IF PLAN CODE = 04 (COHS), THEN
		MUST BE VALID FOR SUBMITTER (VIA PARM?)
		COHS
		HCP CODE SUBMITTER
		502 SANTA BARBARA
		503 SAN MATEO
		504 SOLANO
		505 SANTA CRUZ
		506 ORANGE
		507 NAPA
		508 MONTEREY
		509 YOLO
			PIC X(03)

10	F35C-FI-PROVIDER-TYPE	IF PLAN CODE = 02 OR 09 OR 04 , THEN MUST be valid per working storage table (values listed below). Valid 3-digit Provider Type codes:	PIC X(03)

		001 thru 058; 060 thru 062, 065 thru 067; 072 thru 075; 080 thru 082, 084; 090, 098	
10	F35C-CATEGORY-OF-SERVICE	IF PLAN CODE = 09, THEN MUST NOT CONTAIN ALL SPACES OR ZEROES Data Element 4200 - Category of Service to Provider Type Format 01: Lists provider types and the applicable categories of service for which the provider types are eligible. Format 01 01- 04 Table ID (4200) 05 - 06 Provider Type 07- 10 Blank 11 - 12 Format = Always 01 13 - 80 Categories of Service (2 positions separated by a comma) Format 02: Lists the categories of service and the vendor code used for reporting purposes. Format 02 01 - 04 Table ID (4200) 05 - 06 Provider Type 07- 10 Blank 11 - 12 Format = Always 02 13 - 14 Categories of Service (definition is as follows)* 15 - 16 Vendor Code (definition is as follows)* 17 Blank *Columns 13 -17 repeat as necessary up 13 entries not to exceed column 80. The first two positions are the category of service (for the defined provider type) which will report to the appropriate vendor code (column 15 -16). If all categories are to report to only one vendor code, the first two positions should be 00.	PIC X(03)
10	F35C-PRIMARY-DIAGNOSIS	IF DHS CLAIM TYPE = 2 (INPAT) AND MEDICARE INDICATOR = SPACE, THEN MUST NOT CONTAIN ALL SPACES AND MUST NOT CONTAIN ALL ZEROES.	
15	F35C-PRIM-DIAG-1-5	No Edit	
20	F35C-PRIM-DIAG-1-4	No Edit	
25	F35C-PRIM-DIAG-1-3	Must not contain all zeroes or all spaces.	
30	F35C-PRIM-DIAG-1	No Edit	PIC X(01)
30	F35C-PRIM-DIAG-2	No Edit	PIC X(01)
30	F35C-PRIM-DIAG-3	No Edit	PIC X(01)
25	F35C-PRIM-DIAG-4	No Edit	PIC X(01)

20	F35C-PRIM-DIAG-5	No Edit	PIC X(01)
15	F35C-PRIM-DIAG-6	No Edit	PIC X(01)
15	F35C-PRIM-DIAG-7	No Edit	PIC X(01)
10	F35C-SECONDARY-DIAGNOSIS	field may contain spaces or zeroes, but must be > LOW-VALUES	
15	F35C-SEC-DIAG-1-5	No Edit	
20	F35C-SEC-DIAG-1-4	No Edit	
25	F35C-SEC-DIAG-1-3	No Edit	
30	F35C-SEC-DIAG-1	No Edit	PIC X(01)
30	F35C-SEC-DIAG-2	No Edit	PIC X(01)
30	F35C-SEC-DIAG-3	No Edit	PIC X(01)
25	F35C-SEC-DIAG-4	No Edit	PIC X(01)
20	F35C-SEC-DIAG-5	No Edit	PIC X(01)
15	F35C-SEC-DIAG-6	No Edit	PIC X(01)
15	F35C-SEC-DIAG-7	No Edit	PIC X(01)
10	F35C-EMERGENCY-IND	No Edit	PIC X(01)
10	F35C-ADMIT-TYPE	IF MEDICARE INDICATOR = SPACE, THEN IF PLAN CODE = 02, 04 or 09 AND CLAIM FORM INDICATOR = 'U', THEN MUST = 1, 2, 3, 4, OR 9. These errors should not be set on any claim type other than '2' inpatient	PIC X(01)
10	F35C-PATIENT-STATUS	IF MEDICARE INDICATOR = SPACE, THEN IF PLAN CODE = 02, 04 or 09 AND DHS CLAIM TYPE = 2 (INPAT), THEN If the claim-form-indicator is 'U', THEN the code MUST be valid per working storage table values listed below: 01 thru 09; 20; 30 thru 32; 40 thru 42. 50, 51. If the claim-form-indicator is NOT = 'U', THEN the code MUST be valid per working storage table	PIC X(02)

		values listed below: 00 thru 13; 32	
10	F35C-PRIMARY-SURGERY-CODE	IF DHS CLAIM TYPE = 2 (INPAT) THEN MUST CONTAIN SPACES, ZEROES, OR BE IN RANGE 10000-69999.	PIC X(07)
10	F35C-PRI-SURG-CODE-PROCVAL-IND	Must be >= spaces.	PIC X(02)
10	F35C-SECONDARY-SURGERY-CODE	IF DHS CLAIM TYPE = 2 (INPAT) THEN MUST CONTAIN SPACES, ZEROES, OR BE IN RANGE 10000-69999.	PIC X(07)
10	F35C-SEC-SURG-CODE-PROCVAL-IND	Must be >= spaces.	PIC X(02)
10	F35C-SURGERY-DATE	IF DHS CLAIM TYPE = 2 (INPAT), THEN MUST BE NUMERIC. IF PLAN CODE = 02, 04 or 09 AND DHS CLAIM TYPE = 2 (INPAT), THEN IF > 0, THEN MUST CONTAIN VALID CC, YY,MM,DD. ALSO MUST BE > 0 IF INPAT PRIMARY SURG CODE NOT = SPACES OR ZEROES OR IF INPAT SECONDARY SURG CODE NOT = SPACES OR ZEROES.	PIC X(08)
10	F35C-CLAIM-FORM-INDICATOR	MUST CONTAIN SPACE, 'U', 'H', OR 'N'.	PIC X(01)
10	F35C-ADMIT-SOURCE	IF MEDICARE INDICATOR = SPACE, CLAIM TYPE = ‘2’ AND CLAIM FORM INDICATOR = 'U', THEN MUST BE IN RANGE 1-9, OR 'A' or space. Space = Newborn or Not a transfer or not a UB-92 Claim form. 4 = Transfer from hospital 5 = Transfer from SNF 6 = Transfer from another HCF These errors should not be set on any claim type other than '2' inpatient	PIC X(01)
10	F35C-RELATED-CAUSE-CODES	New Field, Recommended edit: Validate per table of allowed values; AA Auto Accident AB Abuse AP Another Party Responsible EM Employment OA Other Accident (occurs three times)	PIC X(06)
10	F35C-ADMITG-FACILITY-PROV-NUM	Must be Inpatient or Medical Claim	PIC X(10)

10	F35C-CONTRACT-INDICATOR	Must be 'Y', 'N', '0', or ' '	PIC X(01)
10	F35C-CA-DHS-USE-ONLY-FIELDS	The fields in this group are for use only by CA DHCS and MIS/DSS. All file originators should report Spaces (Blanks) in them.	
20	F35C-RECORD-ID-NUMBER	No edit.	PIC S9(15) COMP-3
15	F35C-EDIT-FLAG	No edit.	PIC X(01)
15	F35C-EDIT-FLAG-2	No edit.	PIC X(01)
20	F35C-EDIT-ERROR-CODE-N	No edit.	PIC 9(03)
15	F35C-RECORD-SOURCE-CODE	No edit.	PIC X(02)
05	F35C-CLAIM-DETAILS	No Edit	
10	F35C-DETAIL-SEGMENT OCCURS 0 TO 99 TIMES DEPENDING ON F35C-SEGMENT-CNT INDEXED BY F35C-I1 F35C-I2	No Edit	
12	F35C-MAIN-SEGMENT		
15	F35C-SEGMENT-TYPE-M	Value must be 'M' for Main Type Segment.	PIC X(01)
15	F35C-CCN-LINE-NUMBER	Must be Numeric	PIC 9(02)
15	F35C-DET-MEDI-CAL-AMT-BILLED	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0	PIC S9(7)V9(2) COMP-3
15	F35C-DET-MEDI-CAL-AMOUNT-PAID	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0	PIC S9(7)V9(2) COMP-3
15	F35C-MEDI-CAL-REIMBURSE-AMOUNT	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0	PIC S9(7)V9(2) COMP-3
15	F35C-MEDICARE-AMOUNT-BILLED	MUST BE NUMERIC	PIC S9(7)V9(2) COMP-3

15	F35C-MEDICARE-AMOUNT-PAID	MUST BE NUMERIC	PIC S9(7)V9(2) COMP-3
15	F35C-DET-FROM-DATE-OF-SERVICE	MUST BE NUMERIC. MUST BE > 0. MUST CONTAIN VALID CC, YY,MM,DD AND MUST BE < CHECK DATE. MUST BE <= DETAIL TO-DOS	PIC X(08)
15	F35C-DET-TO-DATE-OF-SERVICE	MUST BE NUMERIC. MUST BE > 0. MUST CONTAIN VALID CC, YY,MM,DD AND MUST BE < CHECK DATE MUST BE >= DETAIL FROM-DOS	PIC X(08)
15	F35C-PCCM-IND	No Edit	PIC X(01)
15	F35C-OHC-CODE	No Edit	PIC X(01)
15	F35C-EPSDT-SERVICE-IND	No Edit	PIC X(01)
15	F35C-MIO-POS	IF MEDICARE INDICATOR = SPACE, THEN MUST be in range 0-8. If Plan Code = 02, 04 , or 09, THEN MUST be valid for FI place of service (POS) per correlation lookup tables in MTR100, working storage 88 levels W-MIO-POS-MATCH and W-MIO-POS-MATCH-2. Blank DHS POS is okay for pharmacy Claim Type 3	PIC X(01)
15	F35C-TAR-CONTROL-NUMBER	Must contain only values A-Z or 1-0 other characters are set to 0	PIC X(11)
15	F35C-DRUG-PROCEDURE-AREA	This area is for reporting information on a drug or medical supply with a UPN number, NDC code, or Medi-Cal drug code. Information on a drug with a HCPCS code would be reported in the other procedure data area that follows this area. IF MEDICARE INDICATOR = SPACES AND PLAN CODE NOT = 05 (CHDP) OR 06 (STATE HOSPITALS) IF PROC INDICATOR = 3 PROC CODE BYTES 1-11 MUST NOT = ALL SPACES OR ZEROES; END-IF IF PROC INDICATOR = 1, PROC CODE BYTES 7-10 MUST NOT = ALL SPACES OR ZEROES AND BYTE 11 MUST = SPACE AND DHS CLAIM TYPE MUST = 2 (INPAT); END-IF	

		IF PROCEDURE INDICATOR = 2, 4, 7, 8, OR 9 PROC CODE BYTES 7-11 MUST NOT = ALL SPACES OR ZEROES AND DHS CLAIM TYPE MUST NOT = 2 (INPAT) END-IF END-IF IF PROC INDICATOR = 3 AND PROC CODE BYTES 5-9 ARE STATE DRUG CODES 9900A-9999Z, and first four bytes are not low-values Error 073 move low-values to first four bytes end-if If first four bytes are low-values Move in-drug-manufacturer to out-drug-manufacturer if bytes 5-9 = '9900A' THRU '9999Z' move 'Y' to Medical-Supply-Ind else move 'N' to Medical-Supply-Ind end-if Search for state drug code on Formulary file If not found error 073 end-if end-if If first four bytes are not = low-values Move spaces to out-drug-manufacturer Search for Procedure-area value on Formulary file If found If formulary pricing indicatory = 'M' or 'I' (incontinence medical supply) Move 'Y' to Medical-Supply-Ind else Move 'N' to Medical-Supply-Ind end-if end-if If not-found move in-medical-supply-ind to out-medical-supply-ind error 078 end-if end-if	
20	F35C-DRUG-PRODUCT-ID-QUALIFIER	Valid values are ‘00’ through ‘13’, ‘99’, and ‘ ‘.	PIC X(02)
20	F35C-DRUG-UNIT-OF-MEASURE	Valid values are ‘EA’, ‘GM’, ‘ML’, ‘UN’, ‘FZ’, and ‘ ‘.	PIC X(02)

20	F35C-DRUG-BASIS-OF-COST-DETERM	No Edit	PIC X(02)
20	F35C-DRUG-REFILL-NUMBER	Must be numeric	PIC 9(02)
20	F35C-DRUG-PART-D-EXCLUDED-IND	Valid values are 'I', 'E'', '0', and ' '.	PIC X(01)
20	F35C-DRUG-NCPDP-REJECT-CODE	Must be >= spaces.	PIC X(03)
20	F35C-DRUG-DISPENSING-FEE-CODE	Valid values are 'A' 'B' 'F' 'I' 'J', 'M', 'P', 'S'.	PIC X(01)
20	F35C-DRUG-DAYS-SUPPLY	MUST BE NUMERIC. IF PLAN CODE = 02, 04 , OR 09 AND DHS CLAIM TYPE = 3 (DRUG), THEN MUST NOT = 0	PIC S9(3) COMP-3
20	F35C-DRUG-UNIT-PRICE	Must be numeric.	PIC S9(7)V99 COMP-3
20	F35C-DRUG-UNITS	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0. IF DHS CLAIM TYPE = 2 (INPAT), THEN IF UB-92 CODE (LAST 3 BYTES) = ANCILLARY CODES 082, 093, OR 250-999, THEN UNITS MUST = 0 Cannot be zero on drug claims.	PIC S9(8)V999 COMP-3
20	F35C-DRUG-PROCEDURE-INDICATOR	IF MEDICARE INDICATOR = SPACE, AND IF PLAN CODE NOT = 05 OR 06, THEN MUST BE APPROPRIATE FOR PROCEDURE CODE FORMAT. IF PROC IND = '3' (STATE DRUG CODE/NDC), THEN PROC CODE BYTES 1-4 MUST = LOW-VALUES OR NOT = SPACES; ELSE IF PROC IND = '9' (HCPCS), THEN PROC CODE BYTES 7-11 MUST = A0001-Z9999; ELSE IF PROC IND = '4' (CPT-4), THEN PROC CODE BYTES 7-11 MUST = 00100-99999; ELSE IF PROC IND = '2' (SMA), THEN PROC CODE BYTES 7-11 MUST = 00001-00099 AND VENDOR CODE MUST = 77; ELSE IF PROC IND = '7' (L.A. Waiv), THEN PROC CODE BYTES 7-11 MUST = 00001-00099;	PIC X(01)

		ELSE IF PROC IND = '1' (UB-92) and VENDOR CODE = 50 OR 60 OR 63 (HIP), THEN PROC CODE BYTES 8-10 MUST = 075-999.	
20	F35C-DRUG-PROCEDURE-CODE	Cannot be > spaces if Other Procedure Code > spaces.	PIC X(20)
25	F35C-DRUG-UPN-NUMBER	No Edit	PIC X(19)
25	F35C-DRUG-NDC-CODE	Valid NDC codes.	PIC X(11)
30	F35C-DRUG-MEDI-CAL-DRUG-CODE	No Edit	PIC X(05)
30	F35C-DRUG-MEDI-CAL-DRUG-MFG	No Edit	PIC X(02)
15	F35C-OTHER-PROCEDURE-AREA	This area is for reporting information on a service or product with a procedure code that is not longer Than 5 characters, such as HCPCS or CPT-4 codes.	
20	F35C-OTHR-PRODUCT-ID-QUALIFIER	No edit	PIC X(02)
20	F35C-OTHR-PROCVAL-INDICATOR	Must be >= spaces.	PIC X(02)
20	F35C-OTHR-UNITS	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0. IF DHS CLAIM TYPE = 2 (INPAT), THEN IF UB-92 CODE (LAST 3 BYTES) = ANCILLARY CODES 082, 093, OR 250-999, THEN UNITS MUST = 0 Cannot be zero on drug claims.	PIC S9(8)V999 COMP-3
20	F35C-OTHR-PROCEDURE-TYPE	Must be >= spaces.	PIC X(01)
20	F35C-OTHR-PROCEDURE-INDICATOR	Must be ‘0’, ‘1’, ‘2’, ‘4’, ‘6’, ‘7’, ‘8’, ‘9’, and space.	PIC X(01)
20	F35C-OTHR-PROCEDURE-CODE	Cannot be > spaces if Drug Procedure Code > spaces. Must be >= spaces.	PIC X(05)
20	F35C-OTHR-INPATIENT-LOCAL-CODE	Must be >= spaces.	PIC X(04)
15	F35C-PROC-MODIFIERS-OR-TEETH		
20	F35C-MODIFIER-OR-TOOTH-1	Must be >= spaces.	PIC X(02)
20	F35C-MODIFIER-OR-TOOTH-2	Must be >= spaces.	PIC X(02)
20	F35C-MODIFIER-OR-TOOTH-3	Must be >= spaces.	PIC X(02)

20	F35C-MODIFIER-OR-TOOTH-4	Must be >= spaces.	PIC X(02)
15	F35C-ACCOMMODATION-CODE	IF MEDICARE INDICATOR = SPACE, THEN IF PLAN CODE = 02, 04, 06, OR 09 AND DHS CLAIM TYPE = 2 (INPAT) AND VENDOR CODE = 47, 56, 57, OR 80 (LTC), THEN MUST NOT CONTAIN SPACES OR ALL ZEROES.	
20	F35C-ACCOM-CODE	No Edit	
25	F35C-ACCOM-1	No Edit	PIC X(01)
25	F35C-ACCOM-2	No Edit	PIC X(01)
20	F35C-ACCOM-H	No Edit	PIC X(01)
15	F35C-DRUG-MANUFACTURER	No Edit	PIC X(02)
15	F35C-PRESCRIPTION-NUMBER	IF PLAN CODE = 02, 04 or 09 AND DHS CLAIM TYPE = 3 (DRUG), THEN MUST NOT CONTAIN ALL SPACES OR ZEROES	
20	F35C-PRESCRIPTION-FIRST-2	No Edit.	PIC X(02)
20	F35C-PRESCRIPTION-LAST-6	No Edit.	PIC X(06)
15	F35C-COPAY-AMOUNT	MUST BE NUMERIC.	PIC S9(7)V99 COMP-3
15	F35C-OHC-COPAY-AMOUNT	MUST BE NUMERIC.	PIC S9(7)V99 COMP-3
15	F35C-PRICE-RESTRICTION	No Edit	PIC X(01)
15	F35C-RENDER-OPERATING-PROV-NUM	For Drug, Outpatient and Medical claims, provider number of the rendering provider. For Inpatient claims, provider number of the operating provider. Must not be < spaces. If Rendering Operating Provider Number > spaces, Claim Type must be ‘03’, ‘04’, ‘05’, or ‘07’.	
20	F35C-REND-OPER-PROV-NPI	No Edit.	
25	F35C-REND-OPER-PROV-NPI-MAIN	No Edit.	PIC X(09)
25	F35C-REND-OPER-PROV-NPI-CHKD	No Edit.	PIC X(01)
15	F35C-REND-OPER-PROV-TAXONOMY	Must be >= spaces.	PIC X(10)
15	F35C-REND-OPER-PROV-OWNER-	Must be >= spaces.	PIC X(02)

	NUMBER		
15	F35C-REFER-PRESCRIB-PROV-NUM	Must not = Low values. If F35C-REFER-PRESCRIB-PROV-NUM = Spaces or Zeroes If Adjustment Indicator = 1 through 6 or Space Then Continue (Okay) Else If Provider county = 01 through 58 If Claim Type = Drug Then Error Else If Claim Type = LTC Then Error.	
20	F35C-REF-PRESC-PROV-NPI	No Edit.	
25	F35C-REF-PRESC-PROV-NPI-MAIN	No Edit.	PIC X(09)
25	F35C-REF-PRESC-PROV-NPI-CHKDIGIT	No Edit.	PIC X(01)
15	F35C-REF-PRESC-PROV-TAXONOMY	Must be >= spaces.	PIC X(10)
15	F35C-EPSDT-REFERR-CDS	No Edit.	PIC X(02)
15	F35C-COPAY-IND	No Edit.	PIC X(01)
15	F35C-FI-TOS	No Edit.	PIC X(01)
15	F35C-DET-OTHER-COVERAGE-AMOUNT	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0.	PIC S9(7)V9(2) COMP-3.
15	F35C-MEDICARE-PAID-AMT-CALC REDEFINES F35C-DET-OTHER-COVERAGE-AMOUNT	No Edit	PIC S9(7)V9(2) COMP-3
15	F35C-ADDITIONAL-FEE	Must be numeric.	PIC S9(7)V9(2) COMP-3.
15	F35C-ORIG-POS-2	If MIO-POS Numeric If MIO-POS Valid (‘0’ through ‘8’) If ORIG-POS-2 = Spaces	

		If Drug Claim or Inpatient Claim Continue Else MIO-POS must match ORIG-POS-2 Else MIO-POS must match ORIG-POS-2 Else Error Else If Drug Claim and MIO-POS = Spaces Continue Else Error.	
20	F35C-ORIG-POS-1	No Edit.	PIC X(01)
20	F35C-POS-1-FILLER	No Edit.	PIC X(01)
15	F35C-SMART-KEY	No Edit	
20	F35C-SMART-KEY-GTC	No Edit	PIC X(02)
20	F35C-SMART-KEY-STC	No Edit	PIC X(04)
20	F35C-SMART-KEY-HICL	No Edit	PIC X(05)
20	F35C-SMART-KEY-STR	No Edit	PIC X(04)
20	F35C-SMART-KEY-DOSE	No Edit	PIC X(03)
20	F35C-SMART-KEY-RT	No Edit	PIC X(02)
20	F35C-SMART-KEY-PS	No Edit	PIC X(03)
20	F35C-SMART-KEY-UDUU	No Edit	PIC X(01)
15	F35C-MEDICAL-SUPPLY-IND	For claim type ‘3’ - Drug Valid values are Y and N (yes and no) for other claim types Y, N, and space The value of this field may be reset based on the edit for the PROCEDURE-AREA	PIC X(01)
15	F35C-TOOTH-SURFACES	No Edit	
20	F35C-TOOTH-SURFACE-1	No Edit	PIC X(01)
20	F35C-TOOTH-SURFACE-2	No Edit	PIC X(01)

20	F35C-TOOTH-SURFACE-3	No Edit	PIC X(01)
20	F35C-TOOTH-SURFACE-4	No Edit	PIC X(01)
20	F35C-TOOTH-SURFACE-5	No Edit	PIC X(01)
15	F35C-BILLED-CODE-IND	No Edit.	PIC X(01)
15	F35C-DET-FFP-IND	IF PLAN CODE = 09, THEN MUST CONTAIN SPACE, 1, 2, OR 3	PIC X(01)
15	F35C-REVENUE-TYPE-CODE	Valid values are: 'NC' 'CM' 'CD' 'OB' 'BT' 'HT' 'HL' 'KT' 'LS' 'LU' 'PT' 'KP' 'EC' 'IN' 'SE' 'SN' 'SD' 'SM' 'PA' 'PB' ' ' 'FQ' 'RH' 'TH' 'MS' 'HS' 'AD'.	PIC X(02)
15	F35C-REVENUE-CODE	Must be >= spaces.	PIC X(04)
15	F35C-DUR-ALERT-DATA		
20	F35C-DUR-CONFLICT-ALERT	Valid values are: ' ' 'AT' 'DA' 'DC' 'DD' 'ER' 'HD' 'IC' 'ID' 'LD' 'LR' 'MD' 'MX' 'PA' 'PG' 'SX' 'TD'.	PIC X(02)
20	F35C-DUR-INTERVENTION-ALERT	Valid values are: ' ' 'M0' 'P0' 'R0'	PIC X(02)
20	F35C-DUR-OUTCOME-ALERT	Valid values are: ' ' '1A' thru '1G' '2A' '2G'	PIC X(02)
15	F35C-COMPOUND-CODE	Valid values are: ' ' '0' '1' '2' If a drug claim, Compound Code must = '2'.	PIC X(01)
15	F35C-COMPOUND-DRUG-ATTACHMENT	No edit.	PIC 9(01)
15	F35C-COMPOUND-DRUG-NBR-INGRED	Must be numeric.	PIC 9(02)
15	F35C-CCS-GHPP-LEGAL-COUNTY	No edit.	PIC X(02)
15	F35C-CCS-GHPP-FUNDING-CATEGORY	No edit.	PIC X(01)
15	F35C-FINANCIAL-INDICATOR	Valid values are: '1' through '7' 'A' 'L' 'M' 'N' ' '.	PIC X(01)
15	F35C-FUNDING-INDICATOR	Must be >= spaces.	PIC X(03)
15	F35C-DET-AID-CODE	Must be spaces, or a valid aid code, or Run type parm = 'BCEDP' and aid code = '9A', or	PIC X(02)

		Run type parm = ‘EDSEAPC’ and aid code = ‘9C’.	
15	F35C-MAIN-SEGMENT-ID-NBR	No edit.	PIC 9(02)
12	F35C-COMPOUND-DRUG-SEGMENT	A COMPOUND DRUG CLAIM RECORD (EFFECTIVE WITH SDN 6043) NORMALLY HAS ONE, AND ONLY ONE, MAIN TYPE SEGMENT AS THE FIRST DETAIL SEGMENT, FOLLOWED BY 0-25 COMPOUND DRUG SEGMENTS. THE NUMBER OF COMPOUND DRUG SEGMENTS DEPENDS UPON THE COMPOUND DRUG NUMBER OF INGREDIENTS. THE SEGMENT COUNT IN THE CLAIM HEADER IS THUS NORMALLY ONE MORE THAN THE COMPOUND DRUG NUMBER OF INGREDIENTS. A DRUG CLAIM RECORD MAY HAVE MULTIPLE MAIN TYPE SEGMENTS THAT ARE FLAGGED AS "COMPOUND DRUG". IN THAT CASE, THERE CAN BE NO COMPOUND DRUG TYPE SEGMENTS (THE COMPOUND DRUG ATTACHMENT AND THE COMPOUND DRUG NUMBER OF INGREDIENTS IN EACH OF THE SEGMENTS MUST BE 0). THAT CONDITION COULD OCCUR ON DRUG CLAIMS PRIOR TO SDN 6043 OR ON DRUG CLAIMS FROM SOURCES OTHER THAN THE MAIN MEDI-CAL FISCAL INTERMEDIARY, SUCH AS COUNTY OPERATED HEALTH SYSTEMS (COHS).	REDEFINES F35C-SEGMENT
15	F35C-SEGMENT-TYPE-C	Value must be 'C' for Compound Type Segment.	PIC X(01)
15	F35C-CMPND-GENERAL-INFO	No Edit	
20	F35C-CMPND-DOSAGE-FORM	Valid values are: ‘01’ through ’07’ ‘10’ through ‘18’	PIC X(02)
20	F35C-CMPND-INCENTIVE-AMOUNT	Must be numeric	PIC S9(7)V9(2) COMP-3
20	F35C-CMPND-FEE	Must be numeric	PIC S9(7)V9(2) COMP-3
20	F35C-CMPND-INCENTIVE-AMOUNT-PD	Must be numeric	PIC S9(7)V9(2) COMP-3
20	F35C-CMPND-ACTUAL-NBR-INGR	Must be numeric	PIC 9(02)

20	F35C-CMPND-ROUTE-OF-ADMIN	Must be numeric	PIC 9(02)
20	F35C-CMPND-UNIT-FORM-IND	Must be numeric	PIC 9(01)
20	F35C-CMPND-CONTAINER-COUNT	Must be numeric	PIC S9(03) COMP-3
20	F35C-CMPND-PROCESS-APPRVD-INGR	No Edit	PIC X(01)
15	F35C-CMPND-INGREDIENT-INFO	No Edit	
20	F35C-CMPND-INGREDIENT-AREA	No Edit	
25	F35C-CMPND-INGR-NDC	No Edit	PIC X(11)
25	F35C-CMPND-INGR-UPN	No Edit	PIC X(19)
25	F35C-CMPND-INGR-PRODUCT-ID	No Edit	PIC X(20)
20	F35C-CMPND-INGR-PROD-ID-QUAL	No Edit	PIC X(02)
20	F35C-CMPND-INGR-BASIS-OF-COST	No Edit	PIC X(02)
20	F35C-CMPND-INGR-DISP-FEE-CODE	No Edit	PIC X(01)
20	F35C-CMPND-INGR-METRIC-QTY	Must be numeric	PIC S9(8)V9(3) COMP-3
20	F35C-CMPND-INGR-BILLED-AMOUNT	Must be numeric	PIC S9(7)V9(2) COMP-3
20	F35C-CMPND-INGR-ALLOWED-AMOUNT	Must be numeric	PIC S9(7)V9(2) COMP-3
20	F35C-CMPND-INGR-REIMBURSE-AMT	Must be numeric	PIC S9(7)V9(2) COMP-3
20	F35C-CMPND-INGR-SMART-KEY		
25	F35C-CMPND-INGR-SMART-KEY-GTC	No Edit	PIC X(02)
25	F35C-CMPND-INGR-SMART-KEY-STC	No Edit	PIC X(04)
25	F35C-CMPND-INGR-SMART-KEY-HICL	No Edit	PIC X(05)
25	F35C-CMPND-INGR-SMART-KEY-STR	No Edit	PIC X(04)

25	F35C-CMPND-INGR-SMART-KEY-DOSE	No Edit	PIC X(03)
25	F35C-CMPND-INGR-SMART-KEY-RT	No Edit	PIC X(02)
25	F35C-CMPND-INGR-SMART-KEY-PS	No Edit	PIC X(03)
25	F35C-CMPND-INGR-SMART-KEY-UDUU	No Edit	PIC X(01)
20	F35C-CMPND-INGR-CUTBACK-REASON	No Edit	PIC X(03)
15	F35C-CMPND-SEGMENT-ID-NBR-X		
20	F35C-CMPND-SEGMENT-ID-NBR	Must be numeric.	PIC 9(02)

APPENDIX B. APPROVED MODIFIERS

For the most current list of approved modifiers click the below link. These are updated from the Medi-Cal Provider Manuals.

http://files.medi-cal.ca.gov/pubsdoco/publications/Masters-MTP/Part2/modifapp_m00o02o03o04o07o09o11a02a04a05a06a08v00.doc

Modifier	Description
21*	Prolonged Evaluation and Management (E & M) services
22*	Unusual services: **Computerized tomography (CT): May be used with computerized tomography codes when additional slices are required or a more detailed evaluation is necessary** **Local Educational Agency (LEA): Denotes an additional 15-minute service increment rendered beyond the required initial service time**
24*	Unrelated E&M service by the same physician during a postoperative period
25*	Significant, separately identifiable E&M service by the same physician on the day of a procedure
26*	Professional component
47*	Anesthesia by surgeon (Not to be used as a modifier for anesthesia codes.)
50*	Bilateral procedure
51*	Multiple procedures
52*$	Reduced services: **Surgical: For use with surgery codes 66800 – 66802, 66820 – 66821, 66830, 66840, 66850, 66915, 66920, 66930, 66940 and 66982 – 66985** **Local Educational Agency (LEA): Denotes an annual re-assessment**
53*$	Discontinued procedure
54*$	Surgical care only (For use only with surgery codes 66800 – 66802, 66820 – 66821, 66830, 66840, 66850, 66915, 66920, 66930, 66940 and 66982 – 66985.)
55*	Postoperative management only
59*	Distinct procedural service (For use only with codes 36818 – 36819 and 76816.)
60$	Altered surgical field
62*	Two surgeons
66*	Surgical team
73$	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia (to be reported by hospital outpatient department or surgical clinic, only)
74$	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia (to be reported by hospital outpatient department or surgical clinic, only)
75	Concurrent care, services rendered by more than one physician
76*	Repeat procedure by same physician
77*	Repeat procedure by another physician
78*	Return to operating room
79*	Unrelated procedure or service
80*	Assistant surgeon
90*	Reference (outside) laboratory when service is performed by an outside laboratory, but billed by another provider. Only specified providers may use this modifier.
99*	Multiple modifiers. Used when two or more modifiers are necessary to completely delineate a service; the multiple modifiers used must be explained in the *Remarks* field (Box 80)/*Reserved For Local Use* field (Box 19) of the claim. (Also used in special circumstances as specified by the California Department of Health Care Services [DHCS]. For an example, refer to the surgery billing examples section in the appropriate Part 2 manual.)
~~AF+~~	~~Anesthesia complicated by total body hypothermia above 30 degrees~~

AG Primary physician:
Surgical: Primary surgeon
Local Educational Agency (LEA): Denotes licensed physicians/psychiatrists

~~AG+~~ ~~mergency anesthesia (moribund patient)~~

AH Clinical psychologist: Used by Local Educational Agency (LEA) to denote licensed psychologists, licensed educational psychologists and credentialed school psychologists

AJ Clinical social worker: Used by Local Educational Agency (LEA) to denote licensed clinical social workers and credentialed school social workers

AN Physician Assistant service

AP Determination of the refractive state was not performed or did not result in a prescription under current FTC rules (ophthalmology only)

~~AS~~ ~~Physician Assistant serving as first assistant in surgery under an approved supervising physician~~ (Removed as an approved modifier for dates of service on or after January 1, 2008).

E1@ Upper left eyelid

E2@ Lower left eyelid

E3@ Upper right eyelid

E4@ Lower right eyelid

ET Emergency services

GN Speech-language pathologist: Used by Local Educational Agency (LEA) to denote licensed speech-language pathologists and speech-language pathologists

GO Occupational therapist: Used by Local Educational Agency (LEA) to denote registered occupational therapists

GP Physical therapist: Used by Local Educational Agency (LEA) to denote licensed physical therapists

GT Service rendered via interactive audio and telecommunications systems

GQ Service rendered by store-and-forward telecommunications system

HA Child/adolescent program

HB Adult program, non-geriatric

HO Used by Local Educational Agency (LEA) to denote program specialists

KC Replacement of special power wheelchair interface

KX Specific required documentation on file

LT Left side (used to identify procedures performed on the left side of the body for prosthetic and orthotic appliance)

NU New equipment (purchase)

P1* Anesthesia services (normal, uncomplicated)

P3* Anesthesia services (a patient with severe systemic disease)

P4* Anesthesia services (a patient with severe systemic disease that is a constant threat to life)

P5* Anesthesia services (a moribund patient who is not expected to survive without the operation)

QE Prescribed amount of oxygen is less than one liter per minute (LPM)

QF Prescribed amount of oxygen exceeds four liters per minute (LPM) and portable oxygen is prescribed

QG Prescribed amount of oxygen is greater than four liters per minute (LPM) and portable oxygen is not prescribed

QS Used by California Children's Services (CCS) to denote monitored anesthesia care

QW CLIA waived tests: Certifies that the provider is performing testing for the procedure with the use of a specific test kit from manufacturers identified by the Centers for Medicare & Medicaid Services (CMS)

RP Replacement and repair

RR Rental

RT Right side (used to identify procedures performed on the right side of the body for prosthetic and orthotic appliance)

SA Nurse practitioner with physician

SB Nurse midwife

SC Medically necessary service/supply

SL Used for Vaccines For Children (VFC) program recipients younger than 18 years of age

SK Members of high risk population
TC Technical component
TD Registered credentialed school nurse: Used by Local Educational Agency (LEA) to denote registered credentialed school nurses, registered credentialed school nurses (who are also registered school audiometrists), licensed registered nurses, certified public health nurses and certified nurse practitioners
TE Licensed practical nurse/Licensed vocational nurse: Used by Local Educational Agency (LEA) to denote licensed vocational nurses
TL Service is part of an Individualized Family Services Plan (IFSP)
TM Service is part of an Individualized Education Plan (IEP)
TS Follow-up service: Used by Local Educational Agency (LEA) to denote an amended re-assessment
TT Additional patient. Used by HCBS Waiver Program to denote services provided to two HCBS NF/AH Waiver recipients who reside in the same residence. Also referred to as shared services.
U1 Medicaid level of service 1/level of care. Used by HCBS Waiver Program to denote skilled nursing services A or B level of care.
U2 Medicaid level of service 2/level of care. Used by HCBS Waiver Program to denote subacute level of care.
U3 Medicaid level of service 3/level of care. Used by HCBS Waiver Program to denote acute level of care.
UD Section 340B services. Used by Section 340B providers to denote services provided or drugs purchased under this program.
UJ Services provided at night
UN Two patients served
UP Three patients served
UQ Four patients served
UR Five patients served
US Six or more patients served
~~Y1#~~ ~~Rental without sales tax (hearing aids)~~
~~Y2#~~ ~~Purchase or repair without sales tax (hearing aids)~~
~~Y6#~~ ~~Rental with sales tax (hearing aids)~~
~~Y7#~~ ~~Purchase, repair, mileage, with sales tax (standard item, hearing aids)~~
~~YQ#~~ ~~Certified Nurse Midwife service (when billed by a physician, organized outpatient clinic or hospital outpatient department)~~
YR Certified Nurse Midwife service (multiple modifiers) (when billed by a physician, organized outpatient clinic or hospital outpatient department)
~~YS#~~ ~~Nurse practitioner service~~
YT Nurse practitioner service (multiple modifiers)
YU Physician Assistant service (multiple modifiers)
YV AIDS Waiver providers only. Administrative expenses when billed by Computer Media Claims (CMC)
YW Required professional experience (applies only to speech therapists and audiologists)
Z1 Additional air mileage in excess of 10 percent of standard airway mileage distances. (Reason for additional mileage flown must be documented on the claim or on an attachment.)
ZA Anesthesia procedures complicated by position or surgical field avoidance
ZB Anesthesia (emergency services, healthy patient)
ZC Anesthesia complicated by extracorporeal circulation
ZD Emergency anesthesia (systemic disease)
ZE Nurse Anesthetist service; elective anesthesia: normal, healthy patient
ZF Anesthesia supervision
ZG Multiple anesthesia modifiers
ZH Nurse Anesthetist service; anesthesia special circumstances: unusual position/field avoidance
ZI Nurse Anesthetist service; anesthesia special circumstances: total body hypothermia
ZJ Nurse Anesthetist service; emergency anesthesia: normal, healthy patient
~~ZK#~~ ~~Primary surgeon~~

ZL Certifies that initial comprehensive antepartum office visit occurred within 16 weeks of the last menstrual period (LMP) (up to and including pregnancies of 16 weeks and 0/7ths days gestation only). Used with procedure code Z1032 only. (Reimbursed only once during pregnancy – service limitation of once in nine months.) Use of this modifier adds $56.63 to reimbursement. Available only to Comprehensive Perinatal Services Program (CPSP) providers. For enrollment information, see the *Pregnancy: Comprehensive Perinatal Services Program (CPSP)* section in the appropriate Part 2 manual.

ZM Supplies and drugs for surgical procedures with other than general anesthesia or no anesthesia

ZN Supplies and drugs for surgical procedures with general anesthesia

ZO Nurse Anesthetist service; anesthesia special circumstances: extracorporeal circulation

ZP Nurse Anesthetist service; elective anesthesia: patient with severe systemic disease that is a constant threat to life

ZQ Family planning counseling. Certifies that family planning counseling was provided during a routine non-family planning office visit. Limited to female recipients 15 – 44 years of age. Can be reimbursed once per recipient per provider in a 12-month period. (For detailed billing information, see the *Family Planning* section in the appropriate Part 2 manual.)

ZR Nurse Anesthetist service; emergency anesthesia: patient with severe systemic disease that is a constant threat to life

ZS Professional and technical component

ZT Nurse Anesthetist service; emergency anesthesia: moribund patient who is not expected to survive without the operation

~~ZU# Exception modifier to 80 percent reimbursement (medical necessity requires common office procedure to be performed in outpatient setting)~~

~~ZV# Exception modifier to 80 percent reimbursement (non-hospital compensated physician called from outside to render emergency service)~~

ZX Nurse Anesthetist service; emergency or elective anesthesia: patient with severe systemic disease

ZY Nurse Anesthetist service; elective anesthesia: moribund patient who is not expected to survive without the operation.

* Check the CPT-4 book for guidelines.

$ Requires 'By Report' documentation.

+ Removed as an approved modifier for dates of service on or after August 1, 2005.

@ Use modifier SC with CPT-4 code 68761 (closure of lacrimal punctum; by plug, each) to indicate use of temporary collagen punctal plugs. Modifiers E1 thru E4 are reserved for permanent silicone punctal plugs.

Removed as an approved modifier for dates of service on or after November 1, 2005.

APPENDIX C. CCS/GHPP BACKGROUND INFORMATION

42.0 CCS/GHPP INDICATOR

California Children's Services (CCS) provides medical and case management services to children with serious medical conditions from low-income families. Eligible conditions include birth defects, chronic diseases, genetic diseases, serious infectious diseases and severe trauma injuries. CCS is administered by county health departments or, for small counties, directly by the three State Children's Medical Services Branch (CMS) regional offices. There are approximately 140,000 children enrolled in the CCS program. About 75% of these children are from families with incomes of less than $40,000 or children with annual medical costs that exceed 20% of their families' income. Cost for services provided to this second group of children are shared equally by the State and the counties.

The Genetically Handicapped Persons Program (GHPP) is administered on a statewide basis by the State CMS Branch. There are approximately 2,000 clients enrolled in GHPP. About half of these clients are eligible for Medi-Cal. Services provided to non-Medi-Cal eligible clients are paid for by the General Fund Patient eligibility, provider enrollment status and type of services rendered determine whether a provider bills under a non-Medi-Cal Provider number (prefix of CGP) or a Medi-Cal Provider number. The provider number identifies the funding source for the claim. Providers submit CCS and GHPP claims to the appropriate CCS or GHPP office. CCS and GHPP authorize services by entering a unique number in the TAR box and either stamping the claims as an indication of approval or attaching an authorization form to the claim. Claims passing this screening are forwarded to Electronic Data Systems Corporation (EDS) for adjudication.

The TAR number must end with an '4' or '8' preceded by 10 zeroes (‘00000000004’, '00000000008').

The TAR number that ends with an '4' means that the services to the Medi-Cal eligible beneficiary under 21 years of age(with a CCS-eligible condition) are benefits of the Medi-Cal program.

The TAR number that ends with an '8' means that the services to the Medi-Cal eligible beneficiary under 21 years of age (with a CCS- eligible condition) are benefits of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services as defined by the Medi-Cal program.

There are also services for children under 21 years of age that are CCS-only or Medi-Cal beneficiaries receiving benefits not payable by the Medi-Cal program. The TAR control number consists of the child's two-digit county code of residence, a one-digit funding code, the child’s' seven-digit CCS number, and a '8'(30212437468). Claims bypass the Recipient ID field and the providers bill using a provider number beginning with the letters ‘CGP’. These claims are paid from CCS program general funds and county appropriations. This background information is from OIL # 219-99 dated September 7, 1999 and OIL # 064-00 dated March 15, 2000.

APPENDIX D. COMPARISON OF PAID CLAIMS FIELDS FOR VARIOUS PLAN CODES

This page is for Electronic Data System's claims.

Plan Code	Claim Types	Type Of Service Code	Description	Procedure Indicator	Code Ranges	Accommodation code ranges
9	2	' '-	Inpat. Long Term Care ' ' ' '		'01 ' - '78 '	
9	2	A -	Inpatient Admittance	6	'3010 '-'3998 '	'01 ' - '09 '
9	2	B -	Inpatient Services	6	'4010 '-'4440 '	'A1 ' - 'R1 '
9	2	A -	Inpatient Admittance	1	'0080 '-'0219 '	'01 ' - '09 '
				1	'1080 '-'1219 '	'01 ' - '09 '
9	2	B -	Inpatient Services	1	'0082 ','0093 '	'A1 ' - 'R1 '
					'0250 '-'0999 '	'A1 ' - 'R1 '
9	2	' '-	LA Waiver Inpatient	7	'0001 '-'0099 '	' '
9	3	D -	RX (Drugs)	3	0000A-9999Z	
9	3	9 -	Other SMA Codes	2	00001-09999	
9	1	'3'-	LA Waiver Outpatient	7	'00060'-'00071'	
9	1,4	1 -	Anesthesia	2	00100-01999	
				4	10000-99999	
9	1,4	2 -	Assistant Surgeons	2	00998-99999	
				4	10000-99999	
9	1,4	3 -	Other CPT-4 Codes			
			Medicine	4	90000-99200	
			Medical Office appts	4	99201-99499	
			Laboratory	4	80000-89999	
			Radiology	4	70000-79999	
			Surgery	4	10000-69999	
			Other	2	00001-09999	
			LA Waiver Outpatient	7	00001-00099	

Note: For Mental Health Inpatient claims, the Provider Code always starts with HSM, has FI Provider type of '72', and has Category of Service of '04'.

Plan Code	Claim Types	Type Of Service Code	Description	Procedure Indicator	Code Ranges	Accommodation code ranges
9	1,4	5 -	Radiology	4	70000-79999	
9	1,4	6 -	Home Health-SMA	2	02600-02640	
		7 -	Not In Use			
9	1,4	8 -	Podiatry	4	10000-99999	

9	1,4	9 - Eye appliances	2	06400-06499	
		3 - Injections	4	00100-01999	
		9 - Other SMA Codes	2	00001-09999	
		9 - HCPCS level II	9	A0000-V9999	
		9 - HCPCS level III - Medicare	9	W0000-W9999 Y0000-Y9999	
		9 - HCPCS level III - Local codes	9	X0000-X9999 Z0000-Z9999	

NOTE: Most information was compiled by researching the claims themselves. The accuracy of the data is not guaranteed since it is impossible to research every claim.

Plan Code	Claim Types	Type Of Service Code	Description	Procedure Indicator	Code Ranges	Accommodation code ranges
0	5	4 - Delta Dental		0	'001 '-'999 '	'@
4	1,4	3 - SBHI's Outpatient & Physician claims		2 4	'0000 '-'9999 ' 10000-99999	' ' ' '
4	2	3 - SBHI's Inpatient Admit.		1	'0080 '-'0219 '	' '
4	2	3 - SBHI's Inpatient Serv.		1	'0082 ','0093' '0250 '-'0999'	' ' ' '
4	3	D - SBHI's RX (Drugs)		3	0000A-9999Z	
4	4	8 - SBHI's Outpatient and Physician claims		4	10000-99999	' '
4	4	9 - SBHI's Outpatient and Physician claims		2	'0000 '-'9999'	' '
4	1,4 5	1,3,- HPSM's Outpatient & Physician claims		4	10000-99999	' '
4	1,4	3 - HPSM's Outpatient & Physician claims		2 4	'0000 '-'9999 ' 10000-99999	' ' ' '
4	2	3 - HPSM's Inpatient Admit.		1	'0080 '-'0219 '	' '

Plan Code	Claim Types	Type Of Service Code	Description	Procedure Indicator	Code Ranges	Accommodation code ranges
4	2	3 - HPSM's Inpatient Serv.		1	'0082 ','0093' '0250 '-'0999'	' ' ' '
4	3	D - HPSM's RX (Drugs)		3	0000A-9999Z	
5	6	' '- EPSDT claims		2	'A001 ' (only)	' '
6	2	A - DSS's Inpatient Admit.		' '	' ' '10 ' - '32 '	
6	2	B - DSS's HCPCS codes unknown		5	00001-99999 meanings	'12 ' & '99 '

8	1	' '- SD/MC Outpatient	8	'1 '-'9 ' '07 ' - '09 ' '12 ', '17 ', and '50 '
8	2	' '- SD/MC Inpatient	8	' ' '07 ' -'09 ', '12 ', '17 ', and '50 '

'

APPENDIX E. COMPARISON OF PROVIDER TYPE/CATEGORY OF SERVICE CODES

01	Adult Day Health Care Centers	81	
02	Assistive Device and Sick Room Supply Dealers	59	39, 61, 65
03	Audiologists	48	15, 47, 65
04	Blood Banks	64, 66	
05	Certified Nurse Midwife	37	11, 12, 13, 32, 33, 72, 92
06	Chiropractors	41	
07	Certified Pediatric Nurse Practitioner and Certified Family Nurse Practitioner	67, 68	11, 12, 13, 32, 33, 72, 92
08	Christian Science Practitioner	51	
09	Clinical Laboratories		34 and/or 35
10	Group Certified Pediatric Nurse Practitioner and Certified Family Nurse Practitioner	67, 68	11, 12, 13, 32, 33, 72, 92
11	Fabricating Optical Laboratory/PIA	57	
12	Dispensing Opticians	61	
13	Hearing Aid Dispensers	65	48
14	Home Health Agencies	52	59, 83
15	Community Hospital Outpatient Departments	09	08, 11, 12, 13, 15, 18, 21, 22, 32, 33, 44, 69, 72, 82, 87, 92
16	Community Hospital Inpatient	02 or 06	18, 20
17	Long Term Care Facility		05, 26, 27, 28, 83
18	Nurse Anesthetists	38	32, 33
19	Occupational Therapists	46	
20	Optometrists	40	61
21	Orthotists	63	39, 59
22	Physicians Group	01	11, 12, 13, 15, 32, 33, 50, 59, 72, 82, 92
23	Optometric Group	40	61
24	Pharmacies/Pharmacist	60	55, 59
25	Physical Therapists	45	
26	Physicians	01	11, 12, 13, 15, 32, 33, 50, 59, 72, 82, 92
27	Podiatrists	43	32, 33, 59, 63
28	Portable X-Ray	31	35
29	Prosthetists	62	39, 59, 63
30	Ground Medical Transportation	69	
31	Psychologists	42	
32	Certified Acupuncturist	36	
33	Genetic Disease Testing	53	
34	LCSW Crossover Provider Only	03	
35	P. L. 95-210 Rural Health Clinics and Federally Qualified Health Centers (FQHCs)	79	
37	Speech Therapists	47	48
38	Air Ambulance Transportation Services	70	
39	Certified Hospice Service Per AB 4249	24	
40	Free Clinics	80	08, 10, 11, 12, 13, 32, 33, 38, 44, 72, 82, 92
41	Community Clinics	80	08, 10, 11, 12, 13, 32, 33, 33, 38, 44, 72, 77, 82, 92
42	Chronic Dialysis Clinics	21	32, 33, 34, 59, 72, 82, 92

43	Multispecialty Clinics	80	08, 11, 12, 13, 15, 21, 22, 32, 33, 44, 72, 82, 88
44	Surgical Clinics	88	08, 11, 12, 13, 32, 33, 72
45	Exempt from Licensure Clinics	80	08, 10, 11, 12, 13, 23, 32, 33, 44, 72, 82, 92
46	Rehabilitation Clinics	22	15, 18, 44, 59, 72, 82, 84, 91
48	County Clinics Not Associated with Hospital	80, 23	08, 10, 11, 12, 13, 16, 32, 33, 38, 44, 72, 82, 92, 94
49	Birthing Center-Primary Care Clinic	78	
50	Clinic – Otherwise Undesignated		08, 72
51	Outpatient Heroin Detoxification Center	82	
52	Alternative Birth Centers-Specialty Clinic	73	11, 12, 13, 32, 33
53	Breast Cancer Early Detection Program (BCEDP)	80	72
54	Expanded Access to Primary Care Clinics	76	
55	Local Education Agency	75	93, 95, 97
56	Respiratory Care Practitioner	86	
57	EPSDT Supplemental Services Provider	58	08
58	Health Access Program	11, 80, 25	12, 13
59	Congregate Living Health Facility (CLHF)	83	
60	County Hospital Inpatient	02 or 06	20
61	County Hospital Outpatient	09, 23	08, 11, 12, 13, 15, 16, 21, 22, 32, 33, 44, 69, 72, 82, 87, 92, 94
62	Group Respiratory Care Practitioners	86	
65	Pediatric Subacute Care - LTC	29, 30	83
66	Service Agency (SA)	83	
67	Individual Nurse Provider		58, 83
68	Individual Licensed Professional (ILP)	83	
69	Professional Organization (PO)	83	
72	Mental Health Inpatient	04	
73	AIDS Waiver Services	96	
74	Multipurpose Senior Services Program (MSSP)	19	
75	Indian Health Services	79	
80	California Children's Service/Genetically Handicapped Person Program-Non-Institutional	99	
80	California Children's Service/Genetically Handicapped Person Program-Institutional	99	
82	Licensed Midwife (LMW)	101	
84	Independent Diagnostic Testing Facility (IDTF) Crossover Provider Only	03	
	Clinical Nurse Specialist (CNS) Crossover Provider Only	03	
90	Out-of-State	90	32, 33

APPENDIX F. COMPOUND DRUG SEGMENT

A compound drug claim record (effective with SDN 06043) normally has one, and only one, main - type 'M' - segment as the first detail segment followed by 0 to 40 compound drug segments.

The first segment must always be a main 'M' segment. If a compound drug segment is present it must always be the second and subsequent segment.

Compound drug claim layout general overview

- Header
- Main Segment (1)
- Compound segments (0-40 or 0-25)

Claims processed by EDS will have 0 to 25 segments. Other data sources may provide up to 40.

When there are compound drug segments the NDC reported in the main segment must be ‘0’ (a single zero) . This is a change per SDN 02024.

The NCPDP standards allow for two types of reporting of compound drugs.

1) All of the ingredients used in the compound drug are reported.
2) Only the most expensive ingredient in the compound is reported.

EDS will use reporting type 1, but will truncate any submission to 25. The actual number of ingredients in the original submission is recorded in the field F35C-CMPND-ACTUAL-NBR-INGR. The record submitted by EDS should have the most expensive ingredients in the 25 that are reported. This is a procedural recommendation, however, not an edit.

Other data sources may use reporting type 1 and provide up to 40 'C' segments.

In the event a data source is using reporting type 2 there will be only one 'C' segment for the compound drug.

The actual number of 'C' segments present on the claim is recorded in the field F35C-COMPOUND-DRUG-NBR-INGRED.

The total number of segments for any compound drug claim with one or more compound drug segments must equal the field F35C-COMPOUND-DRUG-NBR-INGRED + 1.

A compound drug claim record cannot have a segment count of zero, with no detail segments, as the information that the drug is a compound is located on the main segment. Without a main segment it is impossible to know a claim is for a compound drug.

A compound drug may, however, have no compound drug segments. In that case the NDC number on the main segment will be for the compound drug. Using this method a drug claim record may have multiple main type segments that are flagged as ‘compound drug’. But if there are multiple main type segments there can be no compound drug segments. In that case in each of the segments the fields F35C-COMPOUND-DRUG-ATTACHMENT and F35C-COMPOUND-DRUG-NBR-INGRED must be zero. That condition could occur on drug claims prior to SDN 02024 or on drug claims from sources other than EDS, the main Medi-Cal Fiscal Intermediary.

NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS (NCPDP)

The following information is included for reference purposes.

Definitions

COMPOUND INGREDIENT COMPONENT COUNT (447-EC)

Definition A count of each ingredient (both active and inactive) in the compound mixture submitted. The Compound Ingredient Counter Number is incremented for each ingredient submitted.

Purpose Compound counter number associates each ingredient and NDC for reporting, billing, reimbursement and DUR.

COMPOUND INGREDIENT QUANTITY (448-ED)

Definition Amount expressed in metric decimal units of the product included in the compound mixture.

Purpose Data in this field reports the metric decimal quantity of the product used in the compound mixture and facilitates the calculation of the reimbursement amount for this ingredient.

COMPOUND INGREDIENT DRUG COST (449-EE)

Definition Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).

Purpose

COMPOUND DOSAGE FORM DESCRIPTION CODE (450-EF)

Definition The dosage form of the complete compound mixture. The data in this field is reported one time following all iterations of fields 447-EC, 448-ED, and 449-EE.

Purpose When used in combination with field 451-EG, provides a complete description of the compound prescription dispensed.

Values:

1	Capsule	11	Solution
2	Ointment	12	Suspension
3	Cream	13	Lotion
4	Suppository	14	Shampoo
5	Powder	15	Elixir
6	Emulsion	16	Syrup
7	Liquid	17	Lozenge
10	Tablet	18	Enema

COMPOUND DISPENSING UNIT FORM INDICATOR (451-EG)

Definition The total compound metric decimal quantity expressed as Each, Grams, or Milliliters.

Purpose When used in combination with field 450-EF, provides a complete description of the compound prescription dispensed.

Example Describes the units form of the entire compound, such as 10 each, 30 grams, or 1000 milliliters.

Values:
1 = Each
2 = Grams
3 = Milliliters

COMPOUND ROUTE OF ADMINISTRATION CODE (452-EH)

Definition Represents the route of administration of the complete compound mixture.

Purpose The data in this field is used primarily for on-line real-time drug use review in order to avoid unnecessary processing time and screening by the claims processor. This field can be used to selectively apply DUR modules to compounds submitted on-line. For example, in general, topical preparations do not result in drug-drug interactions; thereby the claims processor can bypass this DUR module.

Values:

1 Buccal	12 Other/Miscellaneous
2 Dental	13 Otic
3 Inhalation	14 Perfusion
4 Injection	15 Rectal
5 Intraperitoneal	16 Sublingual
6 Irrigation	17 Topical
7 Mouth/Throat	18 Transdermal
8 Mucous Membrane	19 Translingual
9 Nasal	20 Urethral
10 Ophthalmic	21 Vaginal
11 Oral	22 Enteral

SUBMISSION CLARIFICATION CODE (420-DK) VALUE 8

Definition Process Compound for Approved Ingredients.

Purpose If one or more ingredients are not covered, the claim should be rejected. However, the pharmacist may decide to accept payment excluding the non-covered ingredient(s). A value '08' is resubmitted on a rejected compound prescription when the pharmacist decides to accept payment for all other ingredients, except those not covered by the plan.

REASON FOR SERVICE CODE (439-E4)

Definition Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.

Purpose

CLINICAL SIGNIFICANCE CODE (528-FS)

Definition Code identifying the significance or severity level of a clinical event as contained in the originating database.

COMPOUND ROUTE OF ADMINISTRATION CODE (452-EH)

Definition Code for the route of administration of the complete compound mixture.

COMPOUND INGREDIENT DRUG COST FIELD 449-EE

Definition Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).

REJECT CODE 511-FB

Definition Code indicating the error encountered.

Values:
23 M/I Ingredient Cost Submitted 409

EC = M/I Compound Ingredient Component Counter Number
ED = M/I Compound Ingredient Metric Decimal Quantity
EE = M/I Compound Ingredient Drug Cost
EF = M/I Compound Dosage Form Description Code
EG = M/I Compound Dispensing Unit Form Indicator
EH = M/I Compound Route of Administration Code

INGREDIENT DATA AREA

Fields 407, 423, 436, 437, 447-449 pertain to each compound ingredient.
Note: These fields will be repeated for each ingredient. They are defined below in the order they will appear in the transaction for a single ingredient. Each field is preceded by its field identifier, and followed

by a field separator. Additionally, fields 407, 423, 436 and 437 may also occur in the main body of the transaction.

Field # Field Name
447-EC Compound Ingredient Counter #
407-D7 NDC
423-DN Basis of Cost Determination
436-E1 Alternate Product Type (Optional)
437-E2 Alternate Product Code (Optional)
448-ED Compound Ingredient Metric Decimal Quantity
449-EE Compound Ingredient Drug Cost
Compound Trailing Information Data Area:
Fields 450-452 pertain to the compound trailing information and they apply to the entire compound. Each field is preceded by its field identifier and is followed by a field separator. The transaction ends with field 452-EH.

Field # Field Name
450-EF Compound Dosage Form Description Code
451-EG Compound Dispensing Unit Form Indicator
452-EH Compound Route of Administration Code

FIELD FORMAT VALUES

FIELD #	FIELD NAMES	FORMAT	LENGTH	COBOL PIC
407-D7	NDC NUMBER	A/N	11	X(11)
420-DK	SUBMISSION CLARIFICATION CODE	T	1	9(2)
439-E4	REASON FOR SERVICE CODE	T/A	2	X(2)
423-DN	BASIS OF COST DETERMINATION	A/N	2	X(2)
436-E1	ALTERNATE PRODUCT TYPE (OPTIONAL)	A/N	1	X
437-E2	ALTERNATE PRODUCT CODE (OPTIONAL)	A/N	13	X(13)
447-EC	COMPOUND INGREDIENT COMPONENT COUNTER #	N	2	99
448-ED	COMPOUND INGREDIENT METRIC DECIMAL QUANTITY	N	11	S9(8)V999
449-EE	COMPOUND INGREDIENT DRUG COST D	T, A	8	S9(6)V99
450-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	A/N	2	XX
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	N	1	9
452-EH	COMPOUND ROUTE OF ADMINISTRATION CODE	T, A	2	9(2)
511-FB	REJECT CODE	T, A F	3 4	X(3) X(4)
528-FS	CLINICAL SIGNIFICANCE CODE	T	1	X(1)

APPENDIX G. DATA ELEMENT HISTORY

3.0 Plan Code

02 Encounter Data started in summer of 1994
03 Redwood Health Foundations' (RHF) contract to create Long Paid Claims ended 6/89.)
04 Santa Barbara Health Initiative (SBHI) (Started getting claims 1/87)
04 SANTA CRUZ County Health Options (SCCHO) (set to begin 1/96)
04 NAPA County (began 3/98, then split from NAPA's file 11/98)
04 SOLANO County (began 1/96, had Napa claims in from 3-10/98)
04 CalOptima (Orange county) (began 12/98)
04 Health Plan of San Mateo (HPSM) (Started getting claims 12/87)
09 Computer Sciences Corporation (CSC) before 2/88

NOTE: + Solano included Napa county claims with the incorrect HCP code of 504,(which is Solano's HCP code) instead of 507, which is Napa's HCP code. This was from March 1998 through September 1998. This is supposed to be corrected with the October 98 payment data.

NOTE: * According to the MIS/DSS Project Office, CalOptima had a separate contract with someone to produce their 35-file file for inpatient/outpatient/medical claims. The contract expired at the end of August 2001. Therefore, effective with the August 2001 month of payment, DHS won't get a 35-file from CalOptima for those types of claims. Instead those types of claims will go through the encounter data route at EDS. That means our 35-files from Cal Optima, beginning with August 2001 month of payment, will contain only crossovers (all claim types) and drug claims. Bonnie Williams 10/19/01.

NOTE: ! In the 1970s all health, mental health, and social services were under one department. Before 1980, the groups became their own departments. In the old days the Department of Developmental Services was called Department of Mental Hygiene. Then the Developmental Centers were called State hospitals. Times change as do names, except Data Set Names. This files DSN has the word DMH in it but the file contains no Department of Mental Health claims. Per Howard Auble at DMH on 1/4/2000.

NOTE: A new Title XXI payment tape for all Healthy Family payments (excluding CHDP), including aid code 7X, is scheduled to be implemented by May, 1999, under SDN 8007B. Until SDN 8007B can be implemented, 7X will be reported on the Medi-Cal payment tape. DHS Accounting has agreed to transfer funds until the new payment tape is created. 11/98.

4.0 DHS CLAIM TYPE

DDS, when they create the paid claims for DHS only create inpatient claims. It appears that 95+% of all their October 1999 claims were for vendor code 56 and the other percentage was for vendor code 57. There were 6431 claims for that month of which 1964 claims were marked as an adjusted claim with adjustment indicator code of '1'.

5.0 CLAIM CONTROL NUMBER

As of December 1997 EDS has made some modifications since it was discovered that some services were being paid for under the claim as there is only one place for aid code. Now we have the claims broken up by aid codes so that the right one that allowed the service is the one reflected on the claim. That results in a 2 or more claims whose header fields for the most part Is the same, but maybe the category of service has changed.

6.0 BENEFICIARY ID NUMBER

DHS historically also ran a cross-reference program to put the right serial number on a claim, but that will be discontinued sometime in 2002. As of 1988 a provider can bill with many variations of the 14 character Bene ID or just the CIN or MEDS ID.

7.0 SOCIAL SECURITY NUMBER

This field should never contain the Client Index Number (CIN) or California Driver's License (CDL) number, but when looking at the March 2000 Encounter file, CINs were found in the SSN field! The Encounter file data dictionary dated December 18, 1995 states that their ID field can contain either an SSN or CIN. The MIS/DSS (Management Information System/Decision Support System) does load the CIN into a 9-character field after the Admit Source in the header, but it is not on other Paid Claims as of June 2000.
DHS historically also ran a cross-reference program to put the right serial number on a claim, but that will be discontinued sometime in 2002. As of 1988 a provider can bill with many variations of the 14 character Bene ID or just the CIN or MEDS ID.

8.0 CLIENT INDEX NUMBER --- ONLY ON MIS/DSS CLAIMS

This field was added as of December 1997 for MIS/DSS only.

The MIS/DSS (Management Information System/Decision Support System) loads the CIN into a this field, but it is not on other Paid Claims as of June 2000.

Starting with the May 20th 1999 cut off, California's Healthy Families Program was implemented in the Medi-Cal Short/Doyle system for the Department of Mental Health. Since SSNS are not required for billing, a new ID had to be developed. It was decided to use another pseudo BID number and it consists of the 2 digit county code, 9H (the HFP aid code) or 7X (the HFP bridge code), and '9' + Client Index Number (CIN). EDS claims do not have this requirement, so this format will never be seen on the claims they process.
DHS historically also ran a cross-reference program to put the right serial number on a claim, but that will be discontinued sometime in 2002. As of 1988 a provider can bill with many variations of the 14 character Bene ID or just the CIN or MEDS ID.

11.0 ETHNICITY

Developmental Center's (Plan Code 6) Ethnicity Code before Feb 1992 MOP

	DDS Ethnicity Code	MEDS Code
White	1	1
Black	2	3
Hispanic	3	2
American Indian	4	5
Chinese	5	C
Japanese	6	J
Filipino	7	7
Asian Indian	E	N
Other Asian	8	8
Other Non-white	9	8
Samoan uses Arab	A	8
Unknown	0	8

13.0 PROVIDER ZIP CODE

EDS changed the last 4 characters from spaces to numeric values for the March 1993 file.

Not on Delta Dental claims until 1989. This item was phased in by Delta during 1988. Exact scheme of the phase is not known, but 1989 payment tapes were virtually complete.

14.0 PROVIDER NUMBER

An interesting variation occurred with OIL #253-90. The Department in conjunction with the California Medical Assistance Commission (CMAC), has signed a contract with the six (6) Los Angeles (L.A.) county hospitals which will allow these hospitals to bill the program for inpatient stays provided by a referred facility.

Under the contract, L.A. county hospitals will submit billings for the hospital in which the patient was referred.

These provider numbers will be utilized by L.A. County hospitals in order to bill the Medi-Cal program for services provided. Effective October 23, 1990 date of service.

NOTE: EPSDT, SBHI, HPSM, and EDS all use EDS' provider master file in their systems.

25.0 VENDOR CODE

Vendor Code is not from any claim source. It is a hold over from the old MIO days. It is put in the claims when they are made for DHS's use. Short Paid Claims only has this field and doesn't have room for FI's Provider Type and Category of Service, the Vendor Code is crucial for the programs that utilize this file.

VC 33 became effective for acupuncturist in June 1984;before that they were included in VC 75, organized outpatient clinic services.

Effective January 25, 1991 retro to April 1, 1990, Public Law (PL) 95-210 Rural Health Clinics (RHC) became Federally Qualified Health Centers. Issued a new provider number beginning FHC. These facilities were and still are in vendor code 77 along with other types of RHCs.

Due to a change in Federal reporting requirements regarding Long Term care, the definitions of VC 47 and VC 80 were changed. EDS implemented the change on the paid claims file beginning with the July 1992 month of payment.

Prior to 11/1/92, VC 07 meant Certified Nurse Practitioner for a pilot project for which there were very few claims.

26.0 & 63.0 DISCHARGE/PATIENT STATUS CODE

Pre-UB92 valid values follow for hospital inpatient claims when the Claim Form Indicator is set to ' ':

00 = Still under care
01 = Admitted (Interim Bill)
02 = Expired
03 = Discharged to another acute hospital
04 = Discharged to home
05 = Discharged to a Long Term Care facility

31.0 CHECK DATE

DDS claims contained low-values in this field many years ago, but as of March 2000, it appears that problem was corrected. When this was corrected is unknown.

34.0 C0-INSURANCE AMOUNT

Prior to AB251 (Statutes of 1981), this field reflected both the billed and paid coinsurance amounts for all claim types. After AB251, the coinsurance amount billed was not necessarily paid in full (or at all) for certain outpatient services.

42.0 DAYS-STAY

This field is usually equivalent to the length of stay; however, there have been problems. This field is calculated from data on the claim rather than billed by the provider and is subject to certain edits. The

most recent problem resulted from this field being set to zero for certain county run facilities in Los Angeles. The problem occurred in Mid 1983.

47.0 FFP INDICATOR

This field was added as of June 2000, but DHS will be getting reruns on all claims from December 1999 to populate this field for Family P.A.C.T. (FPACT) claims. All claims with a Date of Service of December 1, 1999 or greater will have this indicator set. Claims with Date of Service prior to December 1, 1999 should have the FFP indicator set to 3.
As of June 2000, this will only be for claims with an aid code of 8H, Family P.A.C.T.(Planning Access Care & Treatment) and each segment detail of the claims should have the indicator set when the aid code is 8H.In the future, this will be done for other aid codes as well.

54.0 RESTRICTED SERVICE CODE

This is also known as the SURS indicator. This is required on EDS claims and comes from MEDS/FAME. It is the first two bytes of the restricted services code.

56.0 RECIPIENT PREPAID HEALTH PLANS(PHP) CODE

Staring at the end of the summer of 1998, SDN 6028B which is part of the Managed Care – 5 HCP Expansion project, has now defined 999 to represent other HCP codes that are not medical for the eligibility period when the service was rendered. The beneficiary may ha e dental or vision or some other HCP, but not one that is medical. Then a 999 is moved to this field

57.0 FI PROVIDER TYPE CODE

This field replaced the old 2 character FI Provider. They ran out of 2 character numeric definitions and opted to go with a 3-character field. All current definitions remains as they are now with a leading zero added on the left most character. So if the Provider Type was 05 it will became 005. The Category of Service also expanded to 3 characters at the same time.

58.0 CATEGORY OF SERVICE

In July of 1999, this field replaced the old 2 character FI Provider. They have almost run out of 2 character numeric definitions and have opted to go with a 3-character field. All current definitions will remain as they are now with a leading zero added on the left most character. So if the Category of Service was 05 it will became 005. The Provider Type also expanded to 3 characters at the same time.

As of the August 2000 file, there are no COS or FI providers that start with a '1'. So as of now both sets of fields have values in them.

OIL # 285-00 dated November 15, 2000 establishes the first 3 character COS, 101 for Licensed Midwife. No effective date as to when this new COS will be installed

59.0 PRIMARY DIAGNOSIS CODE (ICD)

Until the HCFA-1500 forms start in the summer of 1994, physicians were not required by law to enter the diagnosis code. EDS' physician claims receive their diagnosis code in house as EDS reads the claims for processing. EDS trains its staff to determine the diagnosis code where they enter it on the claim. Most other providers do their own coding.

EPSDT and DDS use spaces in this field. Starting with the January 2002 claims, EDS will be receiving both primary and secondary diagnosis codes for pharmacy claims. Practically all pharmacy claims are single line claims, so it has been decided to ask EDS to establish the header primary and secondary diagnosis codes by using the first detail's diagnosis codes.

Vic Walker, Senior Consulting Pharmacist for DHS, does have some comments on the codes:

'By the way, we ought to be cautious about how the pharmacy-submitted diagnoses are used. I have a

lot more confidence in a diagnosis sent me by a physician or hospital than I do in one sent by a pharmacy. The pharmacy, by necessity, will be reporting the diagnosis secondhand, based on what the diagnostician (the physician) told them. There are a lot of reasons why that diagnosis might not be accurate. We might want to put a caution into the data dictionary regarding diagnoses on pharmacy claims.'

So here is the caution in the data dictionary. (July 2001)

80.0 CCN LINE NUMBER

As of December 1997 EDS has made some modifications. It was discovered that some services were being paid for under the wrong aid code that was on the claim as there is only one place for aid code. Now we have the claims broken up by aid codes so that the right one that allowed the service is the one reflected on the claim. That results in a 2 or more claims whose headers fields for the most part are the same, but maybe the category of service has changed. The COBOL program that does that is EDS' MFM320. Their program MFM325 then adds provider information. EDS calls the file out of MFM320 and MFM325, the RFF035 or 35-file.

88.0 PRIMARY CARE CASE MANAGEMENT (PCCM) INDICATOR.

Before the advent of BIC cards, this field was used to create red Medi-Cal cards for Prepaid Health Plan (PHP) and showed the beneficiary had limited coverage and must go to their PHP provider for all other services not listed on the card. Since then this information would appear when eligibility was checked using a Point Of Service (POS) device or other was eligibility was checked.

This field started to show the PCCM Indicator as of February 1990 on EDS created claims only.

Formerly, this field was called the Co-pay Status Code, but as of November 1985 the field became the PCCM indicator on EDS file. Co-pay Status showed the recipients co-pay status during Co-payment experiment from January 1, 1972 to June 30,
1973.

As of August 1991, there is a new Co-pay Indicator.

Before the advent of BIC cards, this field was used to create red Medi-Cal cards for Prepaid Health Plan (PHP) and showed the beneficiary had limited coverage and must go to their PHP provider for all other services not listed on the card. Since then this information would appear when eligibility was checked using a Point Of Service (POS) device or other was eligibility was checked

89.0 OTHER HEALTH CARE(OHC) COVERAGE CODE

Other Health Care Code-previously used

Pay and Chase OHC

M Two or more carriers
X Blue Shield
Y pseudo OHC post recovery code used for cost avoidance cases.
Z Blue Cross

Cost Avoidance OHC

B Blue cross
D prudential
E Aetna
G American General
H Mutual of Omaha
I Metropolitan Life

J John Hancock Mutual Life
Q Equicor/Equitable
S Blue Shield
T Travelers
U Connecticut General (CIGNA)
W Great Western Life Assurance
2 Provident Life and Accident
3 Principal Financial Group
4 Pacific Mutual Life Insurance
5 Alta Health Strategies Inc
6 AARP –Association of Retired Persons
7 Allstate Life Insurance
8 New York Life Insurance

If the recipient's Medi-Cal card is coded with one of the above codes, the provider must bill the other coverage (as well as Medicare, if applicable) before billing Medi-Cal. A copy of the coverage's Explanation Of Benefits (EOB) or denial letter must accompany the Medi-Cal claims to EDS.

This field, for EDS created claims before the February 1990, was defined as Co-pay Procedure, but was space filled and not useable.

Currently, the OHC code in the detail is on EDS created claims only. This field indicates that the recipient does have other health care coverage (OHC).
The field was added in August 1987 when EDS added it to their RFF034 and RFF035-files.
Please refer to the above Cost Avoidance OHC values .

This field is not used on DELTA, SD/MC, EPSDT, or DDS type claims. Other Coverage is any private health insurance plan or Policy under which a recipient is entitled to receive health care services. Other Coverage includes benefits available thought commercial insurance companies, prepaid health plans (PHPs), Health Maintenance Organizations (HMOs), as well as any organization that administers a health plan for professional associations, unions, fraternal groups, employer-employee benefit plans, including self-insured and self-funded plans. Eligibility under Medicare is not considered Other Coverage; however, Medicare supplement policies are considered Other Coverage. The provider of medical services should refer recipients with PHP/HMO coverage to their plans for covered treatment, except in emergencies. Medi-Cal will not reimburse providers for plan covered services, including emergency services, if the recipient chooses to go elsewhere for treatment. There are three kinds of OHC codes, (1) cost avoidance, (2) Prepaid Health Plans/Health Maintenance Organizations (PHP/HMO), and (3) pay-and-chase. When claims come in and the beneficiary's OHC code is a cost avoidance code, the claim is rejected. The provider must bill the insurance carrier first, before Medi-Cal is billed. If the insurance carrier does not pay for that service, the claims is reprocessed with the insurance carrier's rejection, so Medi-Cal will pay. If a pay-and-chase OHC claim comes in, the claim will be paid and the State of California through EDS starting in April 1991 will bill the insurance carriers directly.

NOTE: ‘O’, that's alpha 'oh', is used to override a cost avoidance code. This is called the Two-step Process at DHS's Third Party Liability (TPL) and is for the batch county transactions only. TPL has on-line update ability. The counties must make two transactions to change the OHC code. The first day a change transaction with an 'O'. Once changed to 'O', then OHC can be changed to 'N' if there is no active insurance segments for the month being changed on the Health Insurance System Database (HISDB). To change OHC from a cost avoidance code the change OHC code again is an 'O'. The next day, the new OHC code is entered. If no new code is entered the OHC code field is not updated. If an active insurance segment is found, the incoming OHC code will be reset to the existing OHC code of record or changed to an 'A' or 'N' depending on the value of the existing OHC. If no active insurance segments are found, the OHC will be set to an 'N'. Counties can change any OHC code to 'N' except Healthy Families code for Immediate Need transactions. Counties will not be able to remove a Healthy Families OHC code of '9'. Only a Healthy Families disenrollment transaction can change OHC from a

'9' to an 'N'.

91.0 DHS PLACE OF SERVICE(POS)

The procedure code and/or vendor code is often a better way to determine place of service. Part B crossover claims got Place of Service '2' as a default prior to March 1994 month of payment because a place of service code was not available. Most crossover claims will have an actual place of service code available effective March 1994 month of payment; but if one is not available, the default will be '7' instead of '2'.

93.7 DRUG DISPENSING FEE CODE

Previous values for the dispensing fee code:
A – The Dispensing Fee is equal to 50% of the allowed cost. This corresponds to drugs.
B – The Dispensing Fee is equal to the fixed Dispensing Fee amount found in the first record (that contains fixed prices) on the file. This fee is established via Title 22 and corresponds to drugs coded in section 59999(B) of Title 22.
C – Same as 'A' plus 3 refills in 75 days.
D – Same as 'B' plus 3 refills in 75 days.
E – The Dispensing Fee is subject to minimum quantity cutback.
F - Same as 'E'.
G – The Dispensing Fee is subject to either 4-in-75 minimum quantity cutback.
H – Same as 'G'.
I – The Dispensing Fee is equal to 40% of the negotiated rate for Incontinence Medical Supplies.
M – The Dispensing Fee is equal to 25% of the allowed cost for all medical supplies except incontinence supplies.

93.8 DRUG DAYS SUPPLY

In July of 2000, somebody asked if this was reasonable data. Vic Walker, Senior Consulting Pharmacist for DHS, sent this reply:

We typically DON'T use the data, because we buy national utilization data from Scott Levin which contains DACON (daily consumption), and tend use that, in the hope that maybe it is more accurate. However, I've talked to Scott Levin about their DACON data, and they tell me they don't really do much massaging of the data for reasonableness, etc, so I don't know that it's any better than ours.
The data is reported to us by pharmacies, so it's as accurate as they are. I think it's pretty accurate for tablets and capsules, very unreliable for Eye drops, creams and ointments, inhalers, etc

93.11 & 94.5 PROCEDURE INDICATOR

6 - California Health Facilities Commission Code (CHFC)(obsolete after 1/1/92)

93.12 & 94.6 PROCEDURE CODE

The Uniform Billing codes (UB-82s) were implemented in January 1992.Starting in the fall of 1994, the code name has been renamed to UB-92s.
See UB-92 HOSPITAL INPATIENT ACCOMMODATION CODES for the historical UB-82 codes and conversion scheme to HCFPA codes. It is necessary to use inpatient accommodation codes residing in the accommodation code field, ACCOMMODATION CODE 165 for EDS' LTC (Vendor codes 47 and 80) inpatient claims. This is also true for the Developmental Centers. See Appendix T. DEVELOPMENTAL CENTER CODES (Plan Code 6) for the Developmental Center codes.

SMA (Schedule of Maximum Allowances) codes were replaced by HCPCS Levels II and III codes in September of 1992. The codes are published in the Provider manual. The only other SMAs used are by Rural Health Clinics and Federally Qualified Health Centers (RHC/FQHC). See Appendix U. RURAL

HEALTH BILLING PROCEDURE CODES for that list of codes.

The National Drug Codes are published in the Pharmacy manual. The first 5 characters are the company's number and the federal government assigns it. The company determines the next 6. Usually, but not always, the company assigns the first 4 characters as the description of the drug, such as aspirin, and then the next 2 characters are the package size. (Vic Walker, 6/2000.)

CPT-4 codes replaced RVS/CSN codes for claims for services delivered on or after November 1st, 1987. CPT-4 stands for Current Procedural Terminology Fourth Edition (CPT-4).The CPT codes are published yearly by the American Medical Association.(MediCal only code that resemble CPT-4 codes are published in the provider manuals.) See PROCEDURE INDICATOR for Procedure Indicator codes for RVS and CPT4 codes.

RVS/CSN codes are no longer used on claims for services delivered on or after November 1st, 1987. The codes were replaced by Current Procedural Terminology Fourth Edition(CPT-4). The RVS/CSN was published by the California Medical Association as either:

1. California Standard Nomenclature for Physician's Services; or
2. 1974 Revisions of the 1969 California Relative Values Studies.

California Health Facilities Commission (CHFC) codes were used by hospitals for inpatient billings for various levels of accommodation and related ancillaries. It is necessary to use inpatient accommodation codes residing in the accommodation code field, ACCOMMODATION CODE for EDS' LTC (Vendor codes 47 and 80) inpatient claims. This is also true for the Developmental Centers.
See Appendix T. DEVELOPMENTAL CENTER ACCOMMODATION CODES (Plan Code 6) for the Developmental Centers codes.

NOTE: The CHFC codes have been replaced by Uniform Billing codes (UB-82s) in January 1992. Starting in the fall of 1994, the code name has been renamed to UB-92s.

See UB-92HOSPITAL INPATIENT ACCOMMODATION CODES for the historical UB-82 codes and conversion scheme to HCFPA codes. The Per Discharge Contract Hospital codes are not listed on the conversion scheme. At the time the conversion was in progress I was told not to include them since they may confuse people. If you wish to check out these codes, please refer to the Inpatient/Outpatient Provider Manual on pages 300-108-14 and -15.
See Appendix N. INPATIENT ACCOMMODATION CODES for CHFCA Accommodation and UB-82 procedure codes.

NOTE: L.A. Waiver: L.A. hospitals are exempt from using the standard procedure codes. They have their own unique set of codes. All hospital claims (inpatient and outpatient) will use the. A. Waiver codes. To find these claims use the first 3 characters of provider number. All L.A. Waiver provider numbers start with 'HSW' or 'ZZW'.

See Appendix O. L.A. WAIVER CODES - INPATIENT for L.A. Waiver procedure codes. HCPCS Levels II and III replaced SMA (Schedule of Maximum Allowances) codes in September of 1992. The codes are published in the Provider manual. The only other SMAs used are by Rural Health Clinics and Federally Qualified Health Centers (RHC/FQHC).

See Appendix U. RURAL HEALTH BILLING PROCEDURE CODES for that list of codes.

See PROCEDURE INDICATOR for Procedure Indicator codes for SMA and HCPCS Levels II and III codes. HCPCS levels II and III replaced Delta Dental's California Dental Service (CDS) codes. The implementation date is July 1993 month of payment. The dentists will not bill with them, but Delta will convert them when they send DHS their paid claims files.

See PROCEDURE INDICATOR for Procedure Indicator codes for CDS codes.

EDS only Procedure code formats before March 1994

PROCEDURE INDICATOR FORMAT

"- Long Term Care	5 spaces (use Accommodation code)
"- L.A. Wavier Long Term Care	5 spaces (use Accommodation code)
0 - CDS (Delta Dental) pre 7/93	3 Numeric characters and 2 spaces (replaced by HCPCS 7/93)
1 - UB-92 Inpatient after 1/92	'0' + 3 Numeric characters + 1 space
1 - UB-92 Inpatient after 1/92	'1' + 3 Numeric characters + 1 space
1 - 1964 RVS before the 1980s	4 Numeric characters and 1 space
2 - EPSDT	Always 'A001 '
2 - SMA for EDS	'0' and 4 numeric (replaced by HCPCS Levels II and III except for RHC/FQHC codes)
3 - Drug/Medical Supply Code	4 Numeric characters and 1 alpha (all drug codes & 9900A - 9999Z for medsupp.)
4 - CPT-4 (started 11/87)	5 Numeric characters
5 - 1974 RVS/CSN (CPTs replaced)	5 Numeric characters
6 - CHFC Primary Inpatient	'3' + 3 Numeric characters + 1 space before 1/92
6 - CHFC Secondary Inpatient	'4' + 3 Numeric characters + 1 space before 1/92
7 - L.A. Wavier	'00'+ 2 numeric characters & 1 space
8 - SD/MC Outpatient after 4/92	4 Numeric and 1 space (only on Plan Code 8 claims)
8 - SD/MC Inpatient	5 spaces (use Accommodation code) (only on Plan Code 8 claims)
9 - HCPCS Levels II and III	1 Alpha character and 4 numeric (started 10/92)

Before July, 1999 the last character was a space. Starting with July 1999 claims, the DHS program MFR151 that creates the standard DHS Long Paid Claims was modified to move the second character of the Service Function into the last character. Before 1992, all services were arrayed in groups of 10 starting with 0 and ending in 9; i.e. 20-29. This changed because it was easier to subdivide groups than add new ranges of tens. That means what service was being rendered was not fully known on the claim for many of the subdivided Service Functions range. July was chosen so that Fiscal Year claims would be consistent.

96.0 ACCOMMODATION CODE

It's also used by Short-Doyle/Medi-Cal to denote the mode of service code for hospital inpatient claims. Appendix Q. SHORT-DOYLE/MEDI-CAL CODES.

Lastly, for hospital inpatient claims from EDS, the accommodation code is a converted code based currently on UB-92 accommodation or ancillary codes and previously on CHFC codes. The conversion takes place to simulate the hospital inpatient codes that a previous FI (MIO) used to provide.

See Appendix N. INPATIENT ACCOMMODATION CODES for HCFA Accommodation procedure codes with their matching Accommodation codes.

See Appendix S. MIO 2-DIGIT ACCOMMODATION AND ANCILLARY CODES for old MIO 2-digit Accommodation codes that are used by EDS' reformat program MFM320 to create the accommodation code field. The EDS program MFM320 looks at the HCFA accommodation codes and moves a value to the accommodation code field.

L.A. WAIVER claims do not always use the accommodation code field. Use the procedure code indicator '7' and the procedure code to determine the accommodation if the accommodation code is a space.

99.0 COPAY AMOUNT

Services Subject to Co-payment
Non-emergency Services Provided
in an Emergency Room. $5.00
A non-emergency service is defined as 'any service not required for alleviation of severe pain or the immediate diagnosis and treatment of severe medical conditions that, if not immediately diagnosed and treated, would lead to disability or death.' Such services provided in an emergency room are subject to co-payment.

Outpatient Service$1.00
Physician, optometric, chiropractic, psychology, speech therapy, audiology, acupuncture, occupational therapy, podiatric, surgical center, hospital or outpatient clinic, physical therapy.

Drug Prescriptions$1.00
Each drug prescription or refill.

Per federal law and regulation the following are Exceptions to Copay:

1) Persons age 18 or under.
2) Any woman during pregnancy and the postpartum period (through the end of the month in which the 60-day period following the termination of the pregnancy ends.)
3) Persons who are inpatients in a health facility (hospital,
4) Any child in AFDC-Foster care.
5) Any service for which the program's payments is $10.00 or less.
6) Any hospice patient.
7) Family planning services and supplies.

The co-pay amounts and regulations listed above are from 1982. 4/2000

105.0 REFERRING/PRESCRIBING PROVIDER NUMBER

With the implementation of OIL # 010-00 (in January 2000) and before SDN 7021 is implemented, EDS must now edit to make sure that there is a referring/prescribing/ordering provider number for selected provider claims. The Medical Review Branch of the DHS's Audits and Investigations Division and the Department of Justice's Bureau of Medi-Cal Fraud are impeded in their investigations by the failure of providers to disclose the referring/prescribing/ordering physician's Medi-Cal provider number/license when billing. These numbers are essential to pursuing investigations. EDS is instructed to implement an interim procedure to enforce existing policy; this requires providers to identify the referring/prescribing/ordering physician. This interim procedure will verify that the field for the referring/prescribing/ordering physician is not left blank on the Health Care Financing Administration (HCFA) 1500-claim form. When SDN 7021 is implemented it will edit this field for a valid provider number for specific provider types.

108.0 COPAY INDICATOR

Starting in the August 1991 claims file, the Copay Indicator field was added to the detail. EDS' program MFM320 moves the copay amount for LTC, drug and for L. A. Waiver claims and moves the copay indicator to the RFF035 copay indicator at the same time. 4/2000.

110.0 DETAIL OTHER COVERAGE AMOUNT

This field was added as of March 1994.
This field was originally called MEDICARE PAID AMOUNT-CALCULATED, but as of May 1994, it has been renamed to DETAIL OTHER COVERAGE AMOUNT. All the detail Other Coverage Amount paid are added to create the Header OTHER COVERAGE AMOUNT field.

112.0 ORIGINAL PLACE OF SERVICE

N 'N'o for Drug claims only. 'N' meant the person was not in Long Term Care when they got the prescription.
Y 'Y'es for Drug claims only. 'Y' meant the person was in Long Term Care when they got the prescription.

Note: These two codes are obsolete as of March 1995.

113.0 FIRST DATABANK SMART KEY

Field with number of bytes and example of codes as of 1993

Field (as of 1993)	Bytes	Number of Code
Generic Therapeutic Class (GTC), GTC broad classification; e.g. 20=Antiinfective	2	50
Specific Therapeutic Class (STC), specific classification; e.g.0478=Tetracycline	4	500
Generic Name/Hierarchical Ingredient Code List (HICL) identifies the specific generic entity; e.g. 04003=Tetracycline HCl	5	5860
Drug Strength; (STR) e.g. 0600=250mg	4	2000
Dosage Form (DOSE), e.g. 500=capsule	3	200
Route of Administration (RT), e.g. 01=oral	2	23
Package Size (PS), e.g. 008=100each	3	30
Unit Dose/Unit of Use (UDUU) Identifies special packaging; 0 = doesn't have unit dose or use 1 = unit dose 2 = unit of use	1	3

115.0 TOOTH SURFACE LOCATION

On GMC/Encounter (Geographic Managed Care) data, there is a 5-byte area used for denoting tooth surface, 1 byte for up to 5 occurrences per procedure code. According to dental managed care staff, this 5-byte Tooth Surface Location code must be passed to the RFF035-file which is the basis for providing data to MEDSTAT company for the MIS/DSS (Management Information System; Decision Support System), the relational database developed for DHS**.**

APPENDIX H. DELTA DENTAL CODES

For the most current Delta Dental codes click the below link. These are updated from Denti-Cal Provider Manual: www.denti-cal.ca.gov/provsrvcs/manuals/sec5/Section_5.pdf.

Dental Services	Range of Procedure Codes
Diagnostic	**0100-0999**
Preventive	**1000-1999**
Restorative	**2000-2999**
Endodontic	**3000-3999**
Periodontal	**4000-4999**
Prosthodontic (Removable)	**5000-5899**
Maxillofacial Prosthetic	**5900-5999**
Implant Service	**6000-6199**
Fixed Prosthodontic	**6200-6999**
Oral and Maxillofacial Surgery	**7000-7999**
Orthodontic	**8000-8999**
Adjunctive Service	**9000-9999**

APPENDIX I. DEVELOPMENTAL CENTER ACCOMMODATION CODES

Updated from DDS (Shane Schilling, sschilli@DDS.CA.GOV)

(PLAN CODE 6)

SERVICE	MEDI-CAL ACCOMMODATION CODE
Acute:	
Room Charge	10
Leave day	11
Ancillaries	12
Skilled Nursing:	
Room Charge	20
Leave day	21
Ancillaries	22
Intermediate Care:	
Room Charge	30
Leave day	31
Ancillaries	32
Drugs:	
Drugs	50
Community Clinic:	
Per visit:	70
Physician and Ancillary Medical Services:	
P. & A. services	99

APPENDIX J. EDS CATEGORY OF SERVICE (COS)

Revision 5/10/04

001 Physician Services
002 Inpatient Hospital Services
003 Crossover Provider Only
004 Mental Health Inpatient Services
005 Transitional Care Services-Freestanding Nursing
006 Transitional Care Services-General Acute Care
008 EPSDT Supplemental Services – On-site
009 Hospital Outpatient Department Services
010 Use of Facilities
011 Family P.A.C.T (Planning Access Care & Treatment) Certified Providers
012 TeenSMART Demonstration Project
013 Expanded Clinic Access Demonstration
014 EPSDT Supplemental Services – Supplemental Individual Outpatient Drug Free Counseling for Alcohol and Other Drug (AOD) Problems rendered by Outpatient Drug Free Clinics Only
015 Newborn Hearing Screening
016 Los Angeles County Waiver Facilities Early Discharge Follow Up Visit
017 Incontinence Medical Supplies – DME Providers and Pharmacy Providers
018 Mental Health Services
019 (MSSP) Waiver Services
020 Renal Homotransplantation
021 Chronic Dialysis Services
022 Rehabilitation Center Outpatient Services
023 Directly Observed Therapy (DOT) Services
024 Hospice Services
025 Healthy Families
026 Nursing Facility Services Level A (ICF)/Developmentally Disabled (NF-A/DD)
027 Nursing Facility Services Level A (ICF) (NF-A)
028 Nursing Facility Services Level B (SNF) (NF-B)
029 Pediatric Subacute Care Services
030 Pediatric Subacute Rehabilitation Therapy Services Supplement Ventilator Wearing Services
031 Portable X-Ray Services
032 Clinical Laboratory-CLIA Waived Tests (Must have -QW Modifier to be 'waived')
033 Clinical Laboratory-CLIA Provider Performed Microscopy (PPM)
034 Laboratory & Pathology Services
035 Radiology/Nuclear Medicine Services
036 Acupuncture Services
037 Certified Nurse Midwife
038 Nurse Anesthetist Services
039 Medical Supplies
040 Optometry Services
041 Chiropractic Services
042 Psychology Services
043 Podiatry
044 Skilled Nursing Services
045 Physical Therapy
046 Occupational Therapy
047 Speech Pathology Services
048 Audiological Services
049 Non-Physician Medical Practitioner Services
050 Genetic Counseling Services
051 Christian Science Practitioner Services

052 Home Health Agency Services
053 Expanded Alpha Feto-Protein
054 Prosthetic and Orthotic Asterisk Procedures
055 NCPA/HAS Certified Prosthetic and Orthotic Devices (Title 22, Section 51515{b} {3})
056 Independent Diagnostic Testing Services
057 Fabricating Optical Lab Services
058 EPSDT Supplemental Services
059 Durable Medical Equipment
060 Pharmaceutical Services
061 Optometric Supplies
062 Prosthetic Appliances
063 Orthotic Appliances
064 Blood and Blood Derivatives
065 Hearing Aids
066 Human Milk
067 Certified Pediatric Nurse Practitioner Services
068 Certified Family Nurse Practitioner Services
069 Ground Medical Transportation
070 Air Ambulance Transportation Services
072 Breast Cancer Early Detection Program
073 Alternative Birth Center Services (Specialty Clinic)
074 Surgical Clinic Medicine Services
075 Local Education Agency Services
076 Expanded Access to Primary Care Services
077 Facility Fee – Birthing Services
078 Birthing Center Services
079 PL 95-210 Rural Health Clinic and Federally Qualified Health Centers (FQHC) Services, Indian Health Services
080 Outpatient Clinic Services
081 Adult Day Health Care Services
082 Outpatient Heroin Detox. Services
083 Home & Community Based Services
084 Surgical Services
085 Home Nursing Services
086 Respiratory Care Practitioner Services
087 Psoriasis Day Care
088 Surgical Clinic
089 Hyperbaric Oxygen Therapy, Chamber Change
090 Out of State Provider Services
091 Medicine Services
092 Comprehensive Perinatal Care Services
093 LEA Targeted Case Management (Low)
094 LA County Waiver Facilities OB/Comprehensive Perinatal Services
095 LEA Targeted Case Management (Medium)
096 AIDS Waiver Services
097 LEA Targeted Case Management (High)
098 Miscellaneous
099 CCS/GHPP Services
100 Laboratory Tests Excluded From CLIA Edits
101 Licensed Midwife (LMW) (not currently on the CA-MMIS table)
102 Newborn Screening Test (Genetic Disease Branch)
103 Breast and Cervical Cancer Treatment Program (BCCTP)
104 Wheelchairs (not currently on the CA-MMIS table)
111 Organized Outpatient Clinics (OOC)
115 Breast Cancer Early Detection Program – Breast and Cervical Cancer
118 ALWPP Care Coordinator

119 ALWPP RCFE or HHA
120 Pediatric Palliative Care Waiver Program
777 Temporary HCPCS Category of Service

APPENDIX K. FI RELATED INFORMATION

4.0 DHCS CLAIM TYPE

EDS, when they create the paid claims for DHS for our crossover claims, has to go through some checking to make our claims. All of the crossover claims have FI Claim Type 06 in their main claim type description, but they further identify which type of claim it is by using their claim types 01, 02, 03, 04, 05, and 07 to say if the claim is pharmacy, Long Term Care (LTC) inpatient, hospital inpatient, outpatient, medical/physician, or vision.

These services are billed by long term care facilities on the EDS long term care form (converted to Claim Type 2 for short/long/RFF035 paid claims) for the facilities' convenience and would more appropriately be billed on the outpatient form.

DHS Claim Type	EDS Claim Type
1 = Outpatient	04 Outpatient
2 = Inpatient	02 Long Term Care
	03 Hospital Inpatient
3 = Pharmacy	01 Pharmacy
4 = Medical/Physician	05 Medical
	07 Vision
5 = Dental	not applicable
6 = EPSDT/CHDP	not applicable

5.0 CLAIM CONTROL NUMBER

EDS' Roll number	Definition
01	On-line Claims Corrections
66	SPBU(01-09)
67,75	Physician Attachments Claim (KDE)
68	Tracer Special
69, 71-74	Claims Inquiry Forms (CIF) Systems Test
76	TAR Denied Date Recoupment
77	EPC Adjustment
78-79	Retro-Rate/Adjustment
80	RTD
81	Share Of Cost (SOC)
82-83	Crossover (KDE)
84	Crossover-C020 (KDE)
85-87	Medical Crossover
88	Claims Inquiry Forms (CIF) Crossover
89	Part B - Tape-to-Tape Crossover
90	CHDTP
91, 93	Unassigned
92	Part A - Tape-to-Tape Crossover
94	Treatment Authorization Request (TAR)
95-96	(CALifornia Point of Service)
97	CCS/GHPP
98-99	Appeals

7.0 SOCIAL SECURITY NUMBER

This field may contain an EDS pseudo number. If EDS cannot find a match, they invent a number, just as DHS does. Unfortunately we don't have a cross-reference or access to this file. This number will always end in a 'Q'. You will see this number almost all of the time on Presumptive Eligibility (PE) claims (Aid code 7F and 7G) as SSN is not a requirement for this benefit. The qualified provider of PE must order residency forms and PE benefits cards from DHS. The reason for this is the two forms have pre-printed 14-character beneficiary IDs on them for filling purposes. There is no place to enter a SSN on either form.(The 14 character beneficiary ID is also not kept on MEDS so there is no real way to capture who received PE benefits and then became Medi-Cal eligible for pregnancy related services. The only other identifying information on the PE claims is 12 characters of the last name and 3 characters of the first name and the date of birth. Also many PE claims don't even have anything in the name field at all, so the only personal information on the nameless claims is the date of birth. June 2000 using March 2000 claims for research.)

This field may contain the HAP (Health Access Program) ID. This number will always start with a '9' and end with a 'Y'.

Right now this ID is used for Family P.A.C.T. claims, which have an aid code of 8H. It is possible it will be used for other programs in the future. Also, since the client having the service doesn't have to give their SSN, the name field is usually filled with spaces, zeros, or the words 'NO NAME'. This was discovered by using the March 2000 EDS file while looking for CINs in this SSN field during January 2001.

The Children's Treatment Program (CTP) moves a 9 character ID with the 9th position of the ID of 'J' or a 'K' to the SSN field. This ID is also used to build a 14 character Bene ID with the county code, aid code of '94', 'M', followed by the CTP claim form ID. The claims are for non-Medi-Cal children. When a CTP claim is submitted they must attach a copy of the CHDP claim noting treatment required. EDS takes the pre-imprinted number from the CHDP claim and uses that as the ID number for the CTP claim. They all have the generic 94 as the aid code. These all show up on the CMSP payment tape.

DHS also run these claims against the Healthy Families eligibility file to see if they were within the 90-day period before enrollment into HF, if so, DHS collects the additional FFP for them. So these claims can also appear on the HF claim tape. Giordano, Eve of DHS Payment Systems Division at EDS on-site gave this explanation on 3/14/01 as to why we see claims that in the SSN field has Js and Ks as the ending character. Not on EPSDT except for Supplemental Security Income claims.

9.0 BENEFICIARY NAME

Left justify field, consisting of any or all of the following:

Plan Code	Source	Format
00	DELTA	LLLLLLLLLLLLLF
01	DDS	Last name only
01	DSS	Last name only
02	Encounter	Free format-Last + ' ' + First for up to 10 characters
04	LHPSM	Free format - Last + space + First
04	SBHI	LLLLLLLLLFFFFFF
04	Monterey	Free format and most of the time there is no space between first and last name
05	EPSDT	Last name only
06	DDS	Free format - Last + space + First
08	S/D	Free format
09	EDS	LLLLLLLLLLLFFF

Note: 'L' stands for a character of the last name and 'F' stands for a character of the first name.

10.0 SEX

Plan

Code	Source	Format
00	DELTA	M, F
01	DDS	space
01	DSS	M, F
02	Encounter	M, F
01,02	MIO	1, 2
04	HPSM	M, F
04	SBHI	M, F
04	Monterey	M, F
05	EPSDT	1, 2
06	DDS	M, F
08	S/D	M, F
09	EDS	1, 2

1 or M – Male.
2 or F – Female.
Space – Not Reported

11.0 ETHNICITY (RACE)

Plan Code	Source	Format
00	DELTA	Not currently used
01	DDS	Not currently used
01	DSS	Not currently used
02	Encounter	Sometimes used/sometimes not
04	HPSM	Not currently used
04	SBHI	Not currently used
04	Monterey	Sometimes used/sometimes not
05	EPSDT	Lists ethnicity
06	DDS	Lists ethnicity, but different values until February 1992 when DHS started converting the codes.
08	S/D	Lists ethnicity
09	EDS	Lists ethnicity starting in November 1990.

13.0 PROVIDER ZIP CODE

Monterey county for the last four characters has a mixture of either all spaces, all zeros or the real four characters of the zip code.

14.0 PROVIDER NUMBER

Field Contents for Various Claims

Source	Position	Values
Dental Claims	Bytes 1-2	Zeroes
	Bytes 4-9	Numeric
DDS	Bytes 1-9	Numeric.
DSS	Bytes 1-3	Zeroes
	Bytes 4-9	Alphanumeric
Short Doyle (SD/MC)	Bytes 1-5	Zeroes
	Bytes 6-7	Numeric
	Bytes 8-9	Alphanumeric

Encounter is a mixture. From Encounter Data Dictionary, it says that 'If the service is provided by a Medi-Cal provider, then the Medi-Cal provider number must be used. If the clinic does not have a Medi-Cal provider number, the State clinic license number must be used. If the service is provided by a health facility, the Department of Health Services assigned facility number must be entered. When making entries in the field, enter the entire provider or license number, plan provider identifier number, tax identifier number, or national provider identification number, including all leading and trailing characters.'

18.0 PROVIDER COUNTY

DSS and EPSDT claims have zeros or space sometimes besides real county codes. Encounter sometimes has zeros. Attempts to designate '99' for out-of-state providers have proven to be unsuccessful, but '99' is still used for out-of-state providers.

These codes are the same as Data Element : BENEFICIARY COUNTY for EDS, SBHI, HPSM, SD/MC, DDS claims.

19.0 PROVIDER SPECIALTY

Informal review generally indicates the data to be reasonable for EDS claims as they are the keeper of the main Provider Master File (PMF).

On Delta claims, a '99' indicates the claim was a fee-for- service billing. All other Delta claims will have spaces in this field.
On Monterey claims, this field is used for non-physician claims also. It appears from comparing Vendor Code to the values in this field that there is a mix of codes. Some are true Physician specialty codes and the other codes are provider type. See Appendix G. PROVIDER TYPE CODES for a list of the provider type codes.

26.0 and 63.0 DHCS DISCHARGE/PATIENT STATUS CODE

DHS Discharge /Patient Status		EDS FI Patient Status Correlation Form UB-92	Not Form UB-92
1	Transfer to another hospital	02	03,08,11
2	Transfer to long term care (prior to 4/1/96)	N/A	N/A
	Transfer to Transitional Inpatient Care (eff 4/1/96)	N/A	32
3	Transfer to long term care	03,04	05,13
4	Discharge-deceased	20	02,10

5	Discharged to home	01	04,09,12
6	Still a patient	30,31	00,01
7	Transfer to long term care (obsolete)	N/A	N/A
8	Leave of absence	N/A	06,07
9	Transfer to board and care (obsolete)	N/A	N/A

Encounter claims also use this field for outpatient claims if applicable to the claim. If none of the medical outpatient codes are applicable to the claim, the field is space filled.

27.0 SURGERY

If the claim is an EDS inpatient claim, the primary surgery code is check to see if it is greater than zero. If it is, the surgery code is set to an 'S'.

If the EDS claim is a medical claim, then a check is made for valid Physician/Medical/Vision surgery procedure code codes. The surgery code is set to 'S' if it is any of these codes:

'00100' thru '01999'
'10000' thru '59480'
'59482' thru '59484'
'59488' thru '59599'
'59620' thru '69999'

If the EDS claim is an outpatient, then a check is made for valid surgery procedure code codes. The surgery code is set to 'S' if it is any of these codes:

'10000' thru '59480'
'59482' thru '59484'
'59488' thru '59599'
'59620' thru '69999'

If the EDS claim is an Medicare crossover, claim type is checked to see if it is a outpatient, medical/physician or medical/vision claim (EDS claim type 04, 05, or 07). If it is, then the same group of procedure codes are checked as listed above for the outpatient claims to see if the surgery code is set to 'S'.

28.0 MEDICARE INDICATOR

EDS uses the roll number from the Internal Control Number to set the Medicare Indicator to '1'. If the roll number is between 82 and 90 or is 92, the claim is a Medicare claim. Also if the EDS inpatient type is 06, which means the claim is a Medicare Crossover, this indicator is set to '1'. See INTERNAL CONTROL NUMBER for placement of roll number.

29.0 ADMISSION DATE

This field is frequently unreliable on Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), Long Term Care (LTC), and Medicare/ Medi-Cal inpatient claims since EDS and DDS can be very old dates or zeroes for ongoing cases.
DDS, DSS, SD/MC and EPSDT do not use this field.

30.0 DISCHARGE DATE

May not be reliable for Medicare / Medi-Cal crossover claims.

SD/MC and DDS leave spaces unless person is discharged.

NOTE: EPSDT does not use this field**.**

31.0 CHECK DATE

On EDS processed claims it is the date that EDS sent the payment data to SCO.

For EDS claims, EDS sends the State Controllers Office (SCO) a file listing those providers that need to have checks issued for services rendered. SCO then writes out checks for the providers or does an EFT (Electronic Fund Transfer). The EFTs are done 4 or 5 days after the checks are mailed. When EDS runs MFM320 to create our RFF035-file, they process all the claims that fall in the month that the SCO Warrants are mailed.

34.0 CO-INSURANCE AMOUNT

Encounter records always have zero in this field.

35.0 HEADER OTHER COVERAGE AMOUNT

This field on EDS claims is created from '3rd Party AMT' on EDS' RFF034 file.
DDS, DSS and Encounter are zero filled.

37.0 TOTAL MEDI-CAL PAID AMOUNT

Details show amount approved for payment before any adjustments for patient liability or other offsets. EDS uses the Medi-Cal Reimbursed amounts from each claim line to make the Total Medi-Cal Paid Amount field.

39.0 MEDICARE DEDUCTION CODE

This field is unreliable. On the October 2001 EDS file, out of 1000 records marked as Medicare claims, only 15 had a value of A and the rest were space filled.

EPSDT claims have low-values in this field.

41.0 ADJUSTMENT INDICATOR

When EDS creates adjustment claims, it uses their claim disposition code to set the DHS Paid Claims adjustment code.

DHS Adjustment Code		EDS Claim Disposition Code Correlation
1	Positive supplemental	not applicable
2	Negative supplemental	not applicable
3	Refund to Medi-Cal (negative only)	6 (void), 7 (void to accounts receivable)
4	Positive side of void and reissue	2 (debit adjustment), 3 (retroactive debit adjustment), 4 (accounts receivable debit adjustment)
5	Negative side of void and reissue	5 (credit adjustment)
6	Cash disposition (obsolete)	

Space = not an adjustment
0 (original)
1 (Tape-to-tape crossover)

While EDS does not use adjustment codes of 1, 2, and 6, that does not mean the other claim processors do not use them. The other Plan Codes use DHS adjustment code values.

In October 1999, I was again asked about how to treat adjusted claims. This field is beyond me, but I

knew who to ask so I forward the note on. On the next page is part of the originating note and the answers to the questions:
If I look at the Adjustment Indicator, I see that I can treat all claims with no reversals (space value) as they are. DHS values 4 and 5 are the classic reversals (void and re-issue). Can I treat DHS values of 3 (refund to MediCal) as simply a change in the MediCal paid amount, and not a reversal? If so, I can ignore these claims when I'm counting things, but must combine the paid amounts when I am looking at dollars. True?

On the other hand, can I always ignore the adjustment indicators of 4 and 5? How about adjustment indicators of 1 and 2: I presume I must combine them for costs. Since the adjustment indicator is contained in the header section of the record, I presume that it applies to the entire claim, including all of the details that follow the header. Is this true?

Appreciate any help you can provide!

Inquiring New User of the RFF035-file

Here are the answers:

Adjustment 3 (refund) basically voids out the original claim, so you would want to include them in the count of dollars as well as units or days. I believe these are mostly pharmacy claims that the beneficiary didn't pick up but the pharmacy had already billed for. I think there is a new ruling so that pharmacies are no longer permitted to bill until the prescription is Picked up.

If you ignore Adjustment 4 and 5, you would wind up with the incorrect dollar amount. A lot of these are retroactive adjustments to the original amount paid. So you would want to include them in the count of dollars and it would be fine to include them in counts of units or days since the original will be voided and the reissue will take its place.

Adj. 1 and 2 occur when the dollar amount is being adjusted either up or down and is used in lieu of Adj. 4 and 5. EDS doesn't use Adj. 1 and 2 but some of the county organized health systems (COHS) do. You would want to count these dollars but probably not the units or days. I haven't worked with these kinds of adjustments since EDS doesn't use them so I don't know for sure.

Yes, the Adj. Ind. applies to the whole claim. But be careful with those from COHS since they do things a little oddly due to their system limitations. You could find both positive and negative detail amounts on one of their adjustment claims, but the total of those details should add to the header amounts.

42.0 DAYS STAY

On EDS adjustment claims days stay can be negative, especially those for Vendor Code 47. EDS checks their claim disposition. If it is 5, 6, or 7, it is an adjustment claim, and the days stay field becomes a negative number.

Vendor Code 83 (Pediatric Subacute Rehab/Weaning) is found on Claim Type 2, but in this unique case, the reported Days Stay and Units are not inpatient days. These services are billed by long term care facilities on the EDS long term care form (converted to Claim Type 2 for paid claims) for the facilities' convenience and would more appropriately be billed on the outpatient claim form. When counting inpatient days for long term care, the days reported for Vendor Code 83 should not be included.

SBHI, HPSM, and DDS originating files have admittance and discharge times. Thus, the days stay can be equal to the calculated ‘From’ and ‘To’ dates of service or it may be one day less.

DDS and Encounter may list zeros when the claim crosses months. On Encounter claims the discharge day is not counted unless the patient is admitted and discharged on the same day. The discharge day is counted if the patient expired in the hospital. For example, if a patient was admitted on October 23,

2001, and was discharged alive on October 31, 2001, the days stay for this record would be 008. If the same patient dies instead of being discharged alive on October 31, the days stay would be 009.

43.0 ADJUSTMENT CCN

Delta Dental does not use this but uses the adjustment indicator to identify adjustment claims. See ADJUSTMENT INDICATOR.

44.0 HEADER FROM DATE OF SERVICE (FROM DOS)

For EDS claims, the From Date of Service is the first claim line's date. The To Date of Service is the last claim line's date. All the dates in between can be the same or different.

The FROM and TO Dates of Service can cover more than 2 calendar months.

If a claim is an adjustment or Date of Service is old, two separate claims will probably be created.

On Medi-Cal/Physician (Claim type 4) claims if a beneficiary goes to a physician two or more times in a particular month it is possible to have different FROM Date of Service and TO Date of Service dates. Some doctor offices bill monthly and therefore a claim will list all services rendered and there will be a range in FROM and TO Dates of Service. If the doctor office bills for each service date, the FROM and TO Date of Services will be identical.

46.0 AID CATEGORY

The same aid code that is in the Bene ID. This field is populated from C54-AID-CAT-109. EDS began to always put the DE109 AID CAT aid code into the Bene ID Aid Code. We will have a duplicate of the of the Bene ID Aid Code reported in the new Aid Category field.

47.0 FFP INDICATOR

Space = non-8H aid code (non-FPACT) default

48.0 CROSSOVER STATUS CODE

The above values are derived from the Medicare Status we receive on the FAME eligibility data. The Medicare Status on the FAME file is currently a two-byte field and it is translated to a 1 byte in CA-MMIS.

49.0 OTHER COVERAGE INDICATOR

EDS sets the Other Coverage Indicator to '1', when the claim is not a Medicare crossover and the C54-CLM-3RD-PTY-AMT is not = zero.

50.0 BIRTH DATE

Plan Code	Source	Format
00	DELTA	CCYYMMDD
01	DDS	' '
01	DSS	CCYYMMDD
02	Encounter	CCYYMMDD
01,02	MIO	CCYY
04	HPSM	CCYYMMDD
04	SBHI	CCYYMMDD
05	EPSDT	CCYYMMDD
06	DDS	CCYYMMDD
08	SD/MC	CCY Y
09	EDS	CCYYMMDD

52.0 PROVIDER NAME

This field is a space on EPSDT. Starting with the July 1999 file, SD/MC claims now have the provider name, but before that the field was a space.

DDS starts with last name and then first name starts in column 196.

Encounter data's starts with last name and then first name for individuals. Facilities/clinic names use their normal business name.

Monterey claims for physicians names list 'LASTNAME, MD FIRSTNAME'. Many outpatient clinics have OP in their name. Many hospitals have IP in their name. Many Long Term Care facilities have LTC in their name.

53.0 MINOR CONSENT SERVICE CODE

This is required on EDS claims and comes from MEDS/FAME.

The minor consent code is the last byte of the 3-digit restricted services code on the FAME file. A leading zero is dropped on the RFF035-file because it used to be a two-byte field in the old days.

When a record is identified as a minor consent, MEDS inquiry access by CRT operators is limited based on password authorization to access minor consent records. If an unauthorized person attempts to view a minor consent case on MEDS, the message will say that no record has been found. It happens that many times the child will have a record under their own SSN based on a family's eligibility and a minor consent record. This insures that the adult/guardian/family member involved in the case doesn't have access to this information. The recipient ID used is a pseudo MEDS ID. No address is stored with this record as the Medi-Cal card is issued at the Medi-Cal office for the child.

55.0 FI CLAIM TYPE

01 = Pharmacy (Form 30-1)
02 = Long Term Care (Form 25-1)
03 = Hospital Inpatient (Form 16-1 or UB-92)
04 = Outpatient (Form 15-1 or UB-92)
05 = Medical/Allied (Form 40-1 or HCFA-1500)
06 = code not used at DHS
07 = Vision (Form 45-1)
09 = code not used at DHS

Encounter has data in this field.

DDS and DSS have spaces in this field.

56.0 HEALTH PLAN CODE

DDS and DSS have spaces in this field.

Monterey claims always have their code of 508 in this field.

57.0 FI PROVIDER TYPE CODE

This field is not required from Delta Dental, CHDP, SD/MC or state hospitals. Additions to the list are transmitted via an Operating Instruction Letter (OIL) from DHS' Payment System Division (PSD) to EDS. The codes are on the provider's record on EDS' Provider Master File and on CAMMIS table 0205.

Not on DDS or DSS files.

Monterey does uses this field, but they don't use 3 character one as of their May 2000 file.

58.0 CATEGORY OF SERVICE

Each category of service has multiple service codes. These are obtainable on EDS CA-MMIS table 4201. Updates to this data element are transmitted via an Operating Instruction Letter (OIL) from DHS' Payment System Division (PSD) to EDS.

This field is not required from Delta Dental, CHDP, SD/MC or state hospitals.

Not on DDS, DSS, Monterey or Encounter files.

60.0 SECONDARY DIAGNOSIS CODE(ICD)

Encounter sometimes has data in this field. DDS and DSS have spaces in this field.

62.0 ADMIT TYPE

* Note: There is no delivery admit code for UB-92 claim forms but deliveries can be determined by the existence of procedure codes 59400-59410 or 59510-59525 in either the Primary or Secondary Surgical Code fields.
NOTE: For encounter claims where the newborn remains an in-patient when the mother is discharged '3' is used to identify the newborn's inpatient stay.

80.0 CCN LINE NUMBER

EDS makes an RFF035 using the same 11 character ICN key, so that we usually have one claim with a detail segment for each claim line EDS has processed under that ICN key. This is how the Segment Count field on the file is determined.

On EDS claims the claim line # is always 00. That is why we are moving the real claim line number to the segment, so we have all 13 characters. 00 is moved into the last 2 characters of ICN. Now 14.0 will have the 2 characters to make a whole 13 characters ICN.

82.0 DETAIL MEDI-CAL ALLOWED AMOUNT

ON MIO PROCESSED INPATIENT CLAIMS, THESE DETAILS WERE ADJUSTED TO ACCOUNT FOR AUDIT OFFSETS. CSC AND EDS DO NOT MAKE THIS ADJUSTMENT.

This amount is usually zero on Medicare/Medi-Cal crossover claims. Most claims from contract hospitals have zeros in this field.

83.0 MEDI-CAL REIMBURSED AMOUNT

EDS' Inpatient, Inpatient Crossover and New Part B Crossovers claims do not have claim line reimbursement amounts. Inpatient claims will use the detail Medi-Cal Paid/Allowed Amount reflect the allowed amount for each line from the claim form. The Crossovers will use the total Reimbursement amount for the total/last detail line, while all the other detail lines will contain zeroes.

89.0 OTHER HEALTH CARE COVERAGE

There are three kinds of OHC codes, (1) Cost Avoidance, (2) Prepaid Health Plans/Health Maintenance Organizations (PHP/HMO), and (3) Pay-and-Chase. When claims come in and the beneficiary's OHC code is a cost avoidance code, the claim is rejected. The provider must bill the insurance carrier first, before Medi-Cal is billed. If the insurance carrier does not pay for that service, the claims is reprocessed with the insurance carrier's rejection, so Medi-Cal will pay. If a pay-and-chase OHC claim comes in, the claim will be paid and the State of California, through EDS starting in April 1991 will bill the insurance carriers directly. Each service rendered is coded with an OHC code to say whether that service is covered by the health insurance policy the Medi-Cal beneficiary is carrying. The first detail OHC code is moved to the header OHC code field for easier computer processing. Therefore, it is possible that different OHC codes can be each detail depending if the service rendered was payable under that insurance company's policy.

When a provider is checking for eligibility either using a MOPI (MEDS ONLINE POS INQUIRY) or CATs (common Application Transaction System) or the internet MEDI-CAL site if they have a provider number, etc., this is the kind of message they will get back for the beneficiary on the date of service in question:

LAST NAME : LASTNAME EVC #: 614JG1NF8D.
CNTY CODE: 04. PRMY AID CODE: 39
MEDI-CAL ELIGIBLE W/ NO SOC. OTHER HEA
HEALTH INSURANCE COVERAGE UNDER CODE A
CARRIER NAME: BLUE SHIELD OF CALIFORNIA
HMO. COV:OIM P V.

Other Coverage is any private health insurance plan or policy under which a recipient is entitled to receive health care services. Other Coverage includes benefits available through commercial insurance companies, prepaid health plans(PHPs), Health Maintenance Organizations (HMOs), as well as any organization that administers a health plan for professional associations, unions, fraternal groups, employer-employee benefit plans, including self-insured and self-funded plans.

Eligibility under Medicare is not considered Other Coverage; however, Medicare supplement policies are considered Other Coverage. The provider of medical services should refer recipients with PHP/HMO coverage to their plans for covered treatment, except in emergencies. Medi-Cal will not reimburse providers for plan covered services, including emergency services, if the recipient chooses to go elsewhere for treatment.

If the beneficiary does have eligibility for that date of service a EVC (Eligibility Verification Confirmation) number is assigned and it is used to confirm the beneficiary was eligible in case the claim is denied. Many providers will have print copies of this information just in case.

90.0 EPSDT SERVICE INDICATOR

The EPSDT Service Indicator will only be available on EDS claims.

92.0 TAR CONTROL NUMBER

The first two bytes provide information on the type of TAR that was submitted. The next eight bytes are a serial number that is printed uniquely on each paper TAR form. The final byte (at least for pharmacy TARs) has the following meanings:

0 – Regular TAR
1 – Price Override TAR
3 – Negotiated price TAR

Within this number are various parts that identify claims where the authorization originated. The TAR Control Number will allow a user to track back to the original TAR that was used to approve payment of a claim. In addition, useful information on the type of TAR can be derived from portions of the TAR Control Number.

For all claim types except LTC (Long Term Care), the first two-bytes of the 11-digit TAR Control Number designates the Field Office Unit Code and the 11th digit is the Pricing Indicator.

LTC TAR Control Numbers are only nine bytes long (first two-byte is the Field Office Unit Code followed by a 7-byte sequential number.) The 10th and 11th bytes are zero filled.

93.12 DRUG PROCEDURE CODE or 94.6 OTHER PROCEDURE CODE

Delta Dental codes are published in Title 22, California Code of Regulations, section 51506 as 4-digit codes all beginning with a '9'; however, the code appeared as a 3-digit code without the leading '9' on the paid claims. See Appendix P. DELTA DENTAL CODES for Delta Dental procedure codes before the

change to HCPCS Levels II and III effective with July 1993 month of payment.

93.4 DRUG REFILL NUMBER

Populated from C54-DRUG-REFILL-NUM.

This is not collected on the paper pharmacy claim form, nor is it requested in the Medi-Cal POS Specifications. However, the information is available on many of the NCPDP(National Council of Prescription Drug Programs) transactions received by Medi-Cal.

95.0 TOOTH OR MODIFIER

EPSDT, DDS, and SD/MC claims contain spaces in this field.

96.0 ACCOMODATION CODE

The accommodation code is used by EDS, State Hospitals, Developmental Centers, and county organized health systems to denote long term care facility accommodations. The Long-Term Care (Vendor Codes 47 & 80) claims use 2-digit accommodation codes as prescribed in the Provider Manual and do not use procedure codes. The third byte of this field is always a space.

97.0 DRUG MANUFACTURER

On a Claim Type 3-Pharmacy claim (Vendor Code 26) this is a two position alpha code to identify the drug manufacturer. See VENDOR CODE.

98.0 PRESCRIPTION NUMBER

San Mateo (HPSM), Santa Barbara (SBHI), and Encounter and do not list prescription numbers.

105.0 REFERRING/PRESCRIBING PROVIDER NUMBER

For EDS, these are the referring/prescribing by claim type:

Pharmacy	Prescribing provider
Hospital inpatient	Admitting provider
Outpatient	Rendering Provider
Physician/Medical	Rendering Provider
Vision Rendering Provider	
Long Term Care	Referring Provider

It is on EDS, SBHI, Encounter and HPSM.

Not on SD/MC, EPSDT, DELTA, PCSP and DDS.

Provider types to be checked are:

02 Durable Medical Equipment (DME)
21 Orthotist
24 Pharmacy (HCFA 1500 claim form only)
28 Portable X-Ray
29 Prosthetist

Claims will suspend for this audit if the field on the form is filled in with a space or zeroes, or that the referring provider number is the same as the billing provider number (this indicates self-referring and is in violation of Business and Professions Code, Section 650.01), provider prefixes that start with G*, HS*, LT*, YYY, ZZR, ZZT, and ZZW because these provider prefixes do not designate individual providers.

For encounter files this field will never have a group provider or facility license number. The data dictionary says that if the referring physician is a 'Primary Care Physician (PCP), then the PCP's provider or license number is used. If no referral is given, the filed is left blank. Prescribing Physician: All pharmacy records enter the provider number, license number or Drug Enforcement Authority number of the physician who prescribed the medication or authorized the medical supply. Admitting Physician: For all hospital and long-term care records, enter either the Medi-Cal provider number or the State license number of the physician who admitted the patient into the hospital. Left justify this field with trailing spaces.'

For EDS claims, Karen Royal has given us this information as of December 2001. For Pharmacy and LTC claims, C54-A-REFER-PRESC-PROV-No is mapped to the current 35-file field WS-SEG-PRESC-REFERR-PROV-NO. For inpatient, C54-IN-ADMIT-PROV-NO is mapped to the current 35-file to the current 35-file field WS-SEG-PRESC-REFERR- PROV-NO. For outpatient, C54-OUT-RENDER-PROV-NO is mapped to the current 35-file field WS-SEG-PRESC-REFERR-PROV-NO. For xover(old), C54-IN-ADMIT-PROV-NO (MEDICARE-CLM-TYPE =03 ONLY) is mapped to the current 35-file field WS-SEG-PRESC-REFERR-PROV-NO. For xover(new), C54-XO-RENDER-PROV-NO is mapped to the current 35-file field WS-SEG-PRESC-REFERR-PROV-NO. The current field on the 35-file, WS-SEG-PRESC-REFERR-PROV-NO, will become F35B-PRESC-REF-REND-PROV-NUM on the new 35-file layout.

109.0 FI TYPE OF SERVICE

For EDS, this value is from their procedure master . The EDS type of service is also referred to as the EDS procedure type.

EDS' drug claims do not have type of service code since they come from the Formulary file, not the Procedure code file, which is where EDS keeps their Type of Service code. Starting in March 1994, they will move a 'X' into this field for drug claims.

See APPENDIX X. COMPARISON OF EDS' TYPE OF SERVICE CODES TO DHS's FIELDS for a comparison of EDS' vs. DHS' type of services and other codes.

112.0 ORIGINAL PLACE OF SERVICE

See DHS PLACE OF SERVICE (POS)for a comparison of the respective data elements' place of service codes.

EDS' Long Term Care and Inpatient claims have spaces in this field.

Updated: 6/22/2007

UNITS (Obsolete field)

Generally, this field contains days for inpatient claims but for other claims the interpretation is more difficult. For example, physicians may bill visits, surgeries, anesthesia units, injections, lab procedures, x-rays, etc., and this field describes the quantity of such services. On Pharmacy claims (Claim Type 3 in Data Element 04), the Segment Count (Data Element 02) indicates the number of prescriptions billed on this claim unless the Segment Count equal zero. The units field on Pharmacy claims indicates number of tablets/capsules or medical supply volume.

Vendor Code 83 (Pediatric Subacute Rehab/Weaning) is found on Claim Type 2, but in this unique case, the reported Days Stay and Units are not inpatient days. These services are billed by long term care facilities on the EDS long term care form (converted to Claim Type 2 for paid claims) for the facilities' convenience and would more appropriately be billed on the outpatient claim form. When counting inpatient days for long term care, the days reported for Vendor Code 83 should not be included.

Per Michael K. Fitzwater, Medical Care Statistics Section, April of 2001:
'Claim lines for ancillary services, at least for some hospitals, have numbers other than zero in Units of Service field for hospital inpatient claims. In counting days it will be necessary to check the Procedure Code field to select for inpatient days. This would apply to vendor codes 50 (hospital inpatient), 60 (hospital inpatient) and 63 (mental health inpatient).'
Here is a list of the procedure codes indicating paid days:

For Procedure Indicator = 1
0075 - 0081
0083 - 0092
0094 - 0219
1075 - 1081
1083 - 1092
1094 - 1219
For Procedure Indicator = 7 (L.A. County hospital waiver codes)
0001 – 0099

Nursing facilities (vendor code 80) and Intermediate Care Facilities (vendor code 47) have a blank Procedure Code field, but only have one detail line. A brief scan of these records indicates that only paid days are present in the single detail.

Bonnie Williams suggested that the Days of Stay field would be sufficient for these latter two vendor codes. The sample I am working with indicates that the Days of Stay do equal the Units of Service field for these vendor codes.'

APPENDIX L. INPATIENT REVENUE CODES

REVENUE CODES FOR ACCOMMODATION SERVICES

For the most current Inpatient Revenue codes click on the below link. These are taken from the Medi-Cal Provider Manual, http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part2/revcdip_i00.doc

New National Codes

Revenue Code	Description
111	Room and Board – Private, Medical/Surgical/Gynecological
112	Room and Board – Private, OB
113	Room and Board – Private, Pediatric
114 *	Room and Board – Private, Psychiatric
117	Room and Board – Private, Oncology
118	Room and Board – Private, Rehabilitation
119	Room and Board – Private, Other
121	Room and Board – Semiprivate 2 Bed, Medical/Surgical/Gynecological
122	Room and Board – Semiprivate 2 Bed, Obstetric
123	Room and Board – Semiprivate 2 Bed, Pediatric
124 *	Room and Board – Semiprivate 2 Bed, Psychiatric
127	Room and Board – Semiprivate 2 Bed, Oncology
128	Room and Board – Semiprivate 2 Bed, Rehabilitation
129	Room and Board – Semiprivate, 2 Beds, Other
131	Room and Board – Semiprivate 3 or 4 Bed, Medical/Surgical/Gynecological
132	Room and Board – Semiprivate 3 or 4 Bed, Obstetric
133	Room and Board – Semiprivate 3 or 4 Bed, Pediatric
134 *	Room and Board – Semiprivate 3 or 4 Bed, Psychiatric
137	Room and Board – Semiprivate 3 or 4 Bed, Oncology
138	Room and Board – Semiprivate 3 or 4 Bed, Rehabilitation
139	Room and Board – Semiprivate, 3 and 4 Beds, Other
151	Room and Board – Ward (Medical or General), Medical/Surgical/Gynecological
152	Room and Board – Ward (Medical or General), Obstetric
153	Room and Board – Ward (Medical or General), Pediatric
154 *	Room and Board – Ward (Medical or General), Psychiatric
157	Room and Board – Ward (Medical or General), Oncology
158	Room and Board – Ward (Medical or General), Rehabilitation
159	Room and Board – Ward, Other
169	Room and Board, Other
170	Nursery, General Classification
171	Nursery, Newborn, Level I
172 **	Nursery, Newborn, Level II
173	Nursery, Newborn, Level III
174 ††	Nursery, Newborn, Level IV

200 §	Intensive Care, General Classification
201 ***	Intensive Care, Surgical
202	Intensive Care, Medical
203 ***	Intensive Care, Pediatric
204	Intensive Care, Psychiatric
206	Intensive Care, Intermediate ICU
207 †	Intensive Care, Burn Care
208	Intensive Care, Trauma
209	Intensive Care, Other
210 §	Coronary Care, General Classification
211	Coronary Care, Myocardial Infarction
212	Coronary Care, Pulmonary Care
214	Coronary Care, Intermediate CCU
219	Coronary Care, Other
790	Lithotripsy, General Classification

Key:

** **Revenue code 172 has multiple uses. Refer to the *Obstetrics: Revenue Codes and Billing Policy* section in this manual for details.**

§ These codes have been defined as Medi-Cal benefits in order to provide revenue codes to meet the needs of small hospitals – those with limited bed capacity in ICU or CCU. Small hospitals may bill revenue code 200 to represent either medical ICU (202) or surgical ICU (201) but code 200 may not be used to represent codes 203 – 209. Small hospitals may bill revenue code 210 to represent coronary care, myocardial infarction (211); coronary care, pulmonary care (212); or coronary care, other (219); but code 210 may not be used to represent 214.

******* Transplant services must be billed with an appropriate ICD-9-CM Volume 3 procedure code. Refer to the *Transplants* section for details.

† Use only for licensed burn center beds.

†† Extracorporeal Membrane Oxygenation (ECMO) and Inhaled Nitric Oxide (INO) services must be billed with an appropriate ICD-9-CM Volume 3 procedure code. Refer to the *Medicine* section for details.

UB-92 HOSPITAL INPATIENT ANCILLARY CODES

Ancillary Code	Description (Modified for Medi-Cal Use)
250 †	Pharmacy, General
251 †	Pharmacy, Generic Drugs
252 †	Pharmacy, Non-Generic Drugs
253 † **	Pharmacy, Take-Home Drugs
254 †	Pharmacy, Drugs Incident to Other Diagnostic Services
255 †	Pharmacy, Drugs Incident to Radiology
257 †	Pharmacy, Non-Prescription
258 †	Pharmacy, I.V. Solution
259 †	Pharmacy, Other
270	Medical/Surgical Supplies and Devices, General
271	Medical/Surgical Supplies and Devices, Non-Sterile Supply
272	Medical/Surgical Supplies and Devices, Sterile Supply
274	Medical/Surgical Supplies and Devices, Prosthetic/Orthotic
275	Medical/Surgical Supplies and Devices, Pacemaker
276	Medical/Surgical Supplies and Devices, Intraocular Lens
278	Medical/Surgical Supplies and Devices, Other Implants
279	Medical/Surgical Supplies and Devices, Other Supplies/Devices
290	DME (Other Than Renal Equipment), General

291	DME (Other Than Renal Equipment), Rental
292	DME (Other Than Renal Equipment), Purchase of New DME
293	DME (Other Than Renal Equipment), Purchase of Used DME
299	DME (Other Than Renal Equipment), Other Equipment

300 †	Laboratory, (Lab) General
301 †	Laboratory, Chemistry
302 †	Laboratory, Immunology
304 †	Laboratory, Non-Routine Dialysis
305 †	Laboratory, Hematology
306 †	Laboratory, Bacteriology & Microbiology
307 †	Laboratory, Urology
310	Laboratory, Pathological, General
311	Laboratory, Pathological, Cytology
314	Laboratory, Pathological, Biopsy
320 †	Radiology – Diagnostic, General
321 †	Radiology – Diagnostic, Angiocardiography
322 †	Radiology – Diagnostic, Arthrography
323 †	Radiology – Diagnostic, Arteriography
324 †	Radiology – Diagnostic, Chest X-Ray
329 †	Radiology – Diagnostic, Other
330 †	Radiology – Therapeutic, General
331 †	Radiology – Therapeutic, Chemotherapy Injected
332 †	Radiology – Therapeutic, Chemotherapy – Oral
333 †	Radiology – Therapeutic, Radiation Therapy
335 †	Radiology – Therapeutic, Chemotherapy – I.V.
339 †	Radiology – Therapeutic, Other
340 †	Nuclear Medicine, General
341 †	Nuclear Medicine, Diagnostic
342 †	Nuclear Medicine, Therapeutic
349 †	Nuclear Medicine, Other

350	Computed Tomographic Scan, General
351	Computed Tomographic Scan, Head
352	Computed Tomographic Scan, Body
359	Computed Tomographic Scan, Other
360	Operating Room Services, General
361	Operating Room Services, Minor Surgery
362	Operating Room Services, Organ Transplant Other Than Kidney
367	Operating Room Services, Kidney Transplant
369	Operating Room Services, Other Operating Room Services
370	Anesthesia, General
371	Anesthesia, Incident to Radiology
372	Anesthesia, Incident to Other Diagnostic Services
374	Anesthesia, Acupuncture
379	Anesthesia, Other
380	Blood, General
381	Blood, Packed Red Cells
382	Blood, Whole Blood
383	Blood, Plasma
384	Blood, Platelets
385	Blood, Leukocytes
386	Blood, Other Components

387	Blood, Other Derivatives (Cryoprecipitates)
389	Blood, Other
390	Blood/Blood Component Administration, Processing and Storage, General Classification
391	Blood/Blood Component Administration, Processing and Storage, Administration

400 †	Other Imaging Services, General
401 †	Other Imaging Services, Diagnostic Mammography
402 †	Other Imaging Services, Ultrasound
403 †	Other Imaging Services, Screening Mammography
409 †	Other Imaging Services, Other
410	Respiratory Services, General
412	Respiratory Services, Inhalation Services
413	Respiratory Services, Hyperbaric Oxygen Therapy
419	Respiratory Services, Other
420 †	Physical Therapy, General
430 †	Occupational Therapy, General
439 †	Occupational Therapy, Other
440 †	Speech/Language Pathology, General
449 †	Speech/Language Pathology, Other
450	Emergency Room, General
459	Emergency Room, Other Emergency Room
460	Pulmonary Function, General
470 †	Audiology, General
471 †	Audiology, Diagnostic
472 †	Audiology, Treatment
479 †	Audiology, Other
481	Cardiology, Cardiac Catheterization
489	Cardiology, Other

610 †	Magnetic Resonance Imaging, General
611 †	Magnetic Resonance Imaging, Brain (Including Brainstem)
612 †	Magnetic Resonance Imaging, Spinal Cord (Including Spine)
619 †	Magnetic Resonance Imaging, Other
621	Medical/Surgical Supplies, Incident to Radiology
622	Medical/Surgical Supplies, Incident to Other Diagnostic Services
631 †	Single Source Drug
632 †	Multiple Source Drug
633 †	Restrictive Prescription
634 †	Erythropoietin (EPO) less than 10,000 Units
635 †	Erythropoietin (EPO) 10,000 or more Units
636 †	Drugs Requiring Detailed Coding
710	Recovery Room, General
720	Labor Room/Delivery, General
721	Labor Room/Delivery, Labor
724	Labor Room/Delivery, Birthing Center (Unlicensed Beds)
729	Labor Room/Delivery, Other
730	Electrocardiogram (EKG/ECG), General
731	Electrocardiogram (EKG/ECG), Holter Monitor
740	Electroencephalogram (EEG), General
750	Gastro-Intestinal Services, General
800	Inpatient Renal Dialysis, General
801	Inpatient Renal Dialysis, Hemodialysis

802	Inpatient Renal Dialysis, Peritoneal (Non-CAPD)
803	Inpatient Renal Dialysis, Cont. Ambulatory Peritoneal Dialysis (CAPD)
804	Inpatient Renal Dialysis, Cont. Cycling Peritoneal Dialysis (CCPD)
809	Inpatient Renal Dialysis, Other
922	Other Diagnostic Services, Electromyogram
949	Other Therapeutic Services

Key:

† These are the only ancillary codes that will be reimbursed when billed with administrative days.

****** Quantities of take-home drugs furnished to patients must not exceed a 10-day supply. When the amount for this charge exceeds $50, attach a list of medications, include the name of the drugs, quantities dispensed, dosage prescribed and charges per prescription. For Medicare claims only, take-home drugs must be billed using the non-contract inpatient provider number.

APPENDIX M. L.A. WAIVER CODES – INPATIENT/OUTPATIENT

If a L.A.Waiver code ends in a '9', then it is a contracted hospital per case code. Also all L.A. Waiver provider numbers start with 'HSW' or 'ZZW'.

The L.A.Waiver reflect all-inclusive rates and are defined as follows:

INPATIENT ACCOMMODATION	CODES
Disproportionate Share	0001
* Trauma Transitional Care Unit	0002
* Physician Referral Unit (Medical)	0003
* Physician Referral Unit (Surgical)	0004
Liver	0007
Intensive Medical	0008
Acute Medical	0009
* A.I.D.S.	0010
Surgical	0011
Chest Medicine	0012
Communicable Disease	0013
Clinic Study Center	0014
Surgical - Level I	0016
Surgical - Level II	0017
Surgical - Level III	0018
Surgical - Level IV	0019
Surgical - Level V	0020
Surgical - Level VI	0021
Surgical - Level VII	0022
* Pediatric Intensive Special Care	0023
Surgical - Level VIII	0024
Pediatrics	0025
Surgical - Level IX	0026
Surgical - Level X	0027
Pediatric Intermediate Care (for Olive View Medical Care Center only prov# HSW30040G)	0027
* Surgical - Level XI	0028
* Surgical - Level XII	0029
Intensive Care	0030
Burn ICU	0031
Nursery-Newborn (ineligible mother)	0032
* Surgical - Level XIII	0033
* Surgical - Level XIV	0034
* Psychiatric	0035
* Surgical - Level XV	0036

* NOTE:These L.A. Waiver codes were dropped after the Medi-Cal Operations Division reviewed the claims. EDS has end dated/zero priced these codes with an effective date of service of January 1, 1993.

O.1 L.A. WAIVER CODES - INPATIENT

INPATIENT ACCOMMODATION	CODES

* Surgical - Level XVI 0037
* Surgical - Level XVII 0038
* Surgical - Level XVIII 0039
* Surgical - Level XV 0036
* Surgical - Level XVI 0037
* Surgical - Level XVII 0038
* Surgical - Level XVIII 0039
Ortho-Neuro Acute (Rehab Unit) 0040
Normal Birthing Center (NBC) Mother 0041
Normal Birthing Center (NBC) Nursery 0042
Observation Inpatient 0043
OB Mother 0044
* Surgical - Level XIX 0045
OB Nursery 0046
OB Special Care Nursery (delivery in hosp.) 0047
* Cadaver Kidney Harvest 0048
* Surgical - Level XX 0049
Transitional Living 0050
* Live Donor Kidney 0051
* Cadaver Kidney Acquisition 0053
* Jail 0055
* ICU-Level 2 0058
* ICU-Level 3 0059
* Definitive Observation Unit 0060
* Weekend Therapeutic 0061
* Cadaver Organ Harvest 0070
* Special Intensive Care 0081
* Lowest Acute Rate 0095
OB Duplicate Days 0098
(OB/Nursery Common Day)
Neonatal Intensive Care Unit 0099

Skilled Nursing:

* Skilled Nursing Long-Term Care 0015
Skilled Nursing Administrative Days- 0052
Routine
* Skilled Nursing Long-Term Care 0065
Skilled Nursing Administrative Days- 0095
Heavy Care (also see Inpatient Services)
* Subacute Administrative Days- 0096
With Ventilator
* Subacute Administrative Days- 0097
Without Ventilator

NOTE:These L.A. Waiver codes were dropped after the Medi-Cal Operations Division reviewed the claims. EDS has end dated/zero priced these codes with an effective date of service of January 1, 1993.

O.2 L.A. WAIVER CODES - OUTPATIENT CODES

TRANSITIONAL INPATIENT ACCOMMODATION CODES

Transitional Care-Medical Services 0075
Transitional Care-Rehab Services 0076
Transitional Care-Rehab Patient-Leave 0077

of Absence
Administrative Day-Medical Services 0078
Administrative Day-Rehab Services 0079

GENERAL OUTPATIENT SERVICES CODES

Level of Care:

** All-Inclusive Visit-Level 1 - 3 0060
** All-Inclusive Visit-Level 4 - 5 0061
** All-Inclusive Visit-Level 6 - 10 0062
** All-Inclusive Visit-Level 11 - 13 0063
** All-Inclusive Visit-Level 14 - 15 0064
** All-Inclusive Visit-Level 16 - 18 0066
** All-Inclusive Visit-Level 19 - 20 0067
** All-Inclusive Visit-Level 21 - 23 0068
** All-Inclusive Visit-Level 24 - 35 0069

Note:0060 is also an Inpatient Services code.

0062, 0063, and 0066-0069 also represent various levels of outpatient surgery.

SPECIAL OUTPATIENT SERVICES CODES

Other Outpatient Services:

Outpatient Surgery:

For Rancho Los Amigos Medical Center
* Level I 0068
* Levels II - XIII 0069

For Olive View Medical Center
* Level I 0062
* Levels II - III 0063
* Levels IV - V 0066
* Levels VI 0067
* Levels VII - VIII 0068
* Levels IX - XX 0069
* Outpatient Surgery 0071

** NOTE: While doing research on L.A. Waiver outpatient claims, these codes were found on the RFF035-file. The all have 5 numeric with a leading zero and then the 4 digit code.

L.A. WAIVER CODES - OUTPATIENT SERVICES

GENERAL OUTPATIENT SERVICES CODES

** Special Services 0070
** Outpatient Surgery 0071
** Observation Outpatient 0072

Hyperbaric Chamber:

** Brief 0083
** Limited 0084
* Intermediate 0085
* Extended 0086

SPECIAL OUTPATIENT SERVICES CODES

Psychiatric Outpatient Clinic
* Collateral 0005
* Individual 0006
** Assessment 0087
* Medication 0088
* Group Therapy 0089
** Intensive 0090
* Habilitative 0091
** Community Clients 0092
* Community Outreach 0093
* Case Management - Support * 0094

** Psychiatric Emergency Room 0056
** Psychiatric Consultation 0057

HOME HEALTH SERVICES

** Skilled Nursing 0073
** Physical Therapy 0074
* Occupational Therapy 0075
* Speech Therapy 0076
* Home Health Aide 0077
* Initial Case Evaluation 0078
* Case Re-evaluation 0079
** Physician 0080
** Medical Social Services 0082

** NOTE: While doing research on L.A. Waiver outpatient claims, these codes were found on the RFF035-file. The all have 5 numeric with a leading zero and then the 4-digit code.

L.A. WAIVER CODES - OUTPATIENT SERVICES

Effective April 1989 L.A. Waiver facilities providing comprehensive Prenatal Services were given a new provider number for billing for those services. They also have to use CPT-4 procedure codes like other providers do! These facilities have Vendor Code 75 (organized outpatient clinic) instead of Vendor Code 52 (county hospital-outpatient). The Disproportionate Share code became effective October 1989 retroactive to services rendered on or after July 1, 1988. See Inpatient/Outpatient Bulletin #170, October 1989 for use of this code.

APPENDIX N. LONG TERM CARE (LTC) ACCOMMODATION CODES

Description	Leave Days Regular Services	Non-DD Patient	DD Patient
NF-B Regular	01	02	03
NF-B Rural Swing Bed Program	04	05	N/A
NF-B Special Treatment Program-Mentally Disordered	11	12	N/A
NF-A Regular	21	22	23
Rehabilitation Program-Mentally Disordered	31	32	N/A
ICF Developmental Disability Program	41	N/A	43
ICF/DD-H 4-6 Beds	61	N/A	63
ICF/DD-H 7-15 Beds	65	N/A	68
ICF/DD-N 4-6 Beds	62	N/A	64
ICF/DD-N 7-15 Beds	66	N/A	69
ICF/DD-CN Pilot Program			
ICF/DD-CN Ventilator Dependent	55	----	57
ICF/DD-CN Non-Ventilator Dependent	56	----	58

NF-B Adult Subacute	Regular Services	Bed Hold	Leave of Absence
Hospital DP/NF-B – Ventilator Dependent	71	73	79
Hospital DP/NF-B – Non-ventilator Dependent	72	74	80
Free-standing NF-B – Ventilator Dependent	75	77	81
Free-standing NF-B – Non-ventilator Dependent	76	78	82
NF-B Pediatric Subacute			
Hospital DP/NF-B – Supplemental Rehabilitation Therapy Services	83	N/A	N/A
Hospital DP/NF-B – Ventilator Weaning Services	84	N/A	N/A
Hospital DP/NF-B – Ventilator Dependent	85	87	89
Hospital DP/NF-B – Non-ventilator Dependent	86	88	90
Free-standing NF-B – Ventilator Dependent	91	93	95
Free-standing NF-B – Non-ventilator Dependent	92	94	96
Free-standing DP/NF-B – Supplemental Rehabilitation Therapy Services	97	N/A	N/A
Free-standing DP/NF-B – Ventilator Weaning Services	98	N/A	N/A

APPENDIX O. MIO 2-DIGIT ACCOMMODATION AND ANCILLARY CODES

MIO Accommodation Services

01 = Private Room
02 = Semi-Private Room
03 = Ward
04 = Coronary case
05 = Nursery
06 = Long Term Care
07 = Extended Care or Administrative Days
08 = ICU/CCU
09 = Intermediate Care

Accommodation Services Hours Indicators

The Medi-Cal Inpatient/Outpatient Provider Manual explains why there is the possibility of the third digit of the accommodation code being an 'H'. The next two paragraphs are from that manual.

If an admission was medically necessary and appropriate as determined by the Medi-Cal consultant, and there was reasonable EXPECTATION that the patient would have remained at least overnight, the admission should be authorized as one day of care (even if the patient is discharged or dies later the same day). In this situation HOURLY billing is required for this partial day even though a full day of care has been authorized.

To bill accommodation codes on an hourly basis for non-contract hospitals: Enter the appropriate number of hours followed by the suffix 'H' in the Units of Service box.

To indicate this on the Long Paid Claims file, EDS moves a 'H' to the third digit of the accommodation code field.

1 = Hours in Lieu of Days
2 = Hours in Addition to Days
H = Hours in Lieu of Days
H = Hours in Addition to Days

MIO Ancillary Services

A1 = Operating/Delivery Room
A2 = Anesthesia
A3 = Anesthesia Supplies
B1 = Blood Administration
B2 = Blood Bank
C1 = Inpatient Drugs
C2 = Take-Home Drugs
D1 = X-Ray Exams
E1 = Nuclear Medicine - Diagnostic
E2 = Nuclear Medicine - Therapeutic
E3 = Radiation Therapy
F1 = Laboratory Examinations
F2 = Blood Gases
G1 = EKG, EEG, EMG

* H1 = Cardiology
* I1 = Imaging Services
J1 = Medical - Surgical Supplies
K1 = Physical Therapy
K2 = Occupational Therapy
K3 = Speech Therapy
L1 = Inhalation Therapy (Exclude IPPB)
L2 = IPPB Treatments
M1 = Hospital Compensated Physician
N1 = Acute Hemodialysis
P1 = Other Physical Therapy
* R1 = Emergency Room

* NOTE: These codes were added for the new UB-82 conversion in 1992.

APPENDIX P. PHYSICIAN SPECIALTY CODES

Physician/Non-Physician Medical Practitioner Specialty Codes

Specialty	Code
Allergy	03
Anesthesiology	05
Aviation (MD Only)	11
Cardiovascular Disease (MD Only)	06
Clinics-Mixed Specialty	70
Dentists (DMD)	19
Dermatology	07
Emergency Medicine (Urgent Care)	66
Endocrinology	67
Family Practice	08
Gastroenterology (MD Only)	10
General Practice (General Medicine)	01
General Surgery	02
Geriatrics	38
Hand Surgery	46
Hematology	68
Infectious Disease	77
Internal Medicine	41
Miscellaneous	47
Neoplastic Diseases	78
Nephrology (Renal-Kidney)	45
Neurological Surgery	14
Neurology (MD Only)	13
Neurology-Child	79
Nuclear Medicine	42
Obstetrics	15
Obstetrics-Gynecology (MD Only) Neonatal	16
Oncology	78
Ophthalmology	18
Orthopedic Surgery	20
Otology, Laryngology, Rhinology (ENT)	04
Pathology (MD Only)	22
Pathology-Forensic	90
Pediatric Allergy	43
Pediatric Cardiology (MD Only)	35
Pediatrics	40
Pharmacology-Clinical	91
Physical Medicine & Rehabilitation	25
Plastic Surgery	24

Specialty	Code
Preventive (Internal Medicine)	39
Proctology (Colon & Rectal)	28
Psychiatry	36
Psychiatry-Child	26
Public Health	44
Pulmonary Diseases (MD only)	29
Radiology	30
Rheumatology	83
Surgery-Head & Neck	84
Surgery - Pediatric	85
Surgery-Traumatic	89
Thoracic Surgery	33
Unknown	99
Urology, Urological Surgery	34

Osteopaths Only	
Gynecology	09
Manipulative Therapy	12
Ophthalmology, Otolaryngology, Rhinology	17
Pathologic Anatomy; Clinical Pathology	21
Peripheral Vascular Disease or Surgery	23
Psychiatry Neurology	27
Radiation Therapy	32
Roentgenology, Radiology	31

Non-Physician Medical Practitioner	
Licensed Clinical Social Worker	94
Marriage, Family & Child Counselor	93
Nurse Midwife	4
Nurse Practitioner	2
Physician Assistant	3
Registered Nurse	95

APPENDIX Q. PROVIDER NAMING/NUMBER SYSTEM

CURRENT PROVIDER NUMBER NAMING ACRONYMS

This provider information was enhanced by the Provider Enrollment Section. A special thanks to Mike Lynskey for all his assistance and research during October and November of 1991. The provider type was added to this documentation in February 1993. Updated 3/00.

On EDSNET, their provider status codes are 1 = active, 2 = not active, 3 = pending, and 4 = deceased.

ACCRONYM	PROVIDER TYPE	NAME OF PROVIDER TYPE
AC	032	CERTIFIED ACUPUNCTURISTS
ABC	049	ALTERNATIVE BIRTHING CENTERS
ABS	041	ALTERNATIVE BIRTHING SERVICES
ADU	001	ADULT DAY CARE CENTERS
AU	003	AUDIOLOGISTS
AYD	073	AIDS PROVIDERS
BB004	BLOOD BANKS	
BCP053	BREAST CANCER PROGRAM	
CCS	046	CCS CERTIFIED REHAB CLINIC FOR MEDI-CAL ELIG CCS PATIENTS
CGP	080	PROVIDERS FOR THE CCS/GHPP PROGRAM =NON-INST.
CGP	081	PROVIDERS FOR THE CCS/GHPP PROGRAM =INSTITUT.
CDC	042	CHRONIC DIALYSIS CLINICS
CLN	041	COMMUNITY CLINICS
CLF	059	CONGREGATE LIVING HEALTH FACILITIES
CMM	041	COMMUNITY CLINICS
CNP	007	CERTIFIED NURSE PRACTITIONERS (Discontinued-new is NP)
CSP	008	CHRISTIAN SCIENCE PRACTICIANER
CSW	034	CLINICAL SOCIAL WORKER (LICENSED--LCSW)
CT	019	CERTIFIED OCCUPATIONAL THERAPISTS
DC	006	DOCTOR OF CHIROPRACTIC
DIAA	045	DIAGNOSTIC MAGNETIC IMAGING CTRS(enrolled as exempt)
DIAB	045	DIAGNOSTIC MAGNETIC IMAGING CTRS(enrolled as exempt)
DME	002	DURABLE MEDICAL EQUIPMENT
DX	012	DISPENSING OPTICIANS
EAP	054	EXPANDED ACCESS TO PRIMARY CARE CLINIC
EMP	047	EMPLOYER/EMPLOYEE CLINIC
EPS	034	EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT
EPSL	034	EPSDT ONSITE INVESTIGATIONS TO DETECT THE SOURCE OF LEAD
EXE	045	EXEMP FROM LICENSURE CLINICS

ACCRONYM	PROVIDER TYPE	NAME OF PROVIDER TYPE
FHC	035	FEDERALLY QUALIFIED HEALTH CTRS(enrol'd as rural h.)
GDTF	033	GENETIC DISEASE TESTING FUND
G***	Any	'G' INDICATES A GROUP OF THE TYPE ASSOC. WITH PREFIX
G***	Ind.	OF PROV TYPE; A GROUP OF AUDIOLOGISTS WILL BE 'GAU'
GNP	010	GROUP NURSE PRACTITIONERS (PEDIATRIC & FAMILY SERV.)

```
  GPS  031   PSYCHOLOGISTS GROUP
  GR   022   PHYSICIAN GROUP
  GRE  026   PODIATRIC GROUP
  GRR  022   PHYSICIAN GROUP WITH A REGIONAL CENTER(DEPT DEV.SER)
  GRR**  Any  REGIONAL CENTER GROUP,WITH ADDED LETTERS TO INDICATE
```
Type; A GROUP OF AUDIOLOGISTS WILL BE ‘GRRAU’
```
  GRT  056
  GRX  098   MISCELLANEOUS FOR CROSSOVER PAYMENTS
  GSD  023   OPTOMETRY GROUPS
  HA   013   HEARING AID DISPENSERS
  HAP  058   FAMILY PLANNING
  HDC  051   OUTPATIENT HEROIN DETOX CENTERS
  HHA  014   HOME HEALTH AGENCIES
  HPC  039   HOSPICE PROVIDERS
  HSC  016   COMMUNITY HOSPITAL INPATIENT (CONTRACTED)
  HSD  016&060 SPECIAL ‘SHELL’ NUMBER FOR ‘DISPROPORTINATE (can't
         bill
  HSD  016&060 SHARE’ PAYMENTS TO ELIGIBLE IN-PATIENT HOSPITALS x-
         overs)
  HSM      MENTAL HEALTH HOSPITAL for hospital inpatient only
  HSP0  016   COMMUNITY HOSPITAL--INPATIENT (NON-CONTRACTED)
         Some are MENTAL HEALTH CONSOLODATION.
  HSP1  016   COMMUNITY HOSPITAL--INPATIENT (non active now)
  HSP2  016   COMMUNITY HOSPITAL--INPATIENT - OUT OF STATE
  HSP3  016   COMMUNITY HOSPITAL--INPATIENT (NON-CONTRACTED)
  HSM3  072   MENTAL HEALTH CONSOLODATION
  HSM4  015   COMMUNITY HOSPITAL OUTPATIENT MOBILE VANS
  HSP5  --   NEVER HAVE USED THIS PREFIX
  HSP6  016   COMMUNITY HOSPITAL--INPATIENT - OUT OF STATE
  HSP7-9 --   THESE PREFIXES NEVER USED
  HST  016&060 INPATIENT HOSPITALS-TRANSITIONAL CARE (can't bill
         x-overs)
  HSW  060   INPATIENT HOSPITALS-L.A. COUNTY WAIVER
  HCX  016&060 HOSPITAL CONSTRUCTION FUNDS - USED ONLY FOR AR PMTS.
  LAB  009   CLINICAL LABORATORIES
  LAB7  009   CLINICAL LABORATORIES-BUILT FROM THE CLIA NUMBER
  LAW  048   L.A. WAIVER COUNTY CLINICS
  LMW  082   LICENSED MIDWIFE
  LTC  017   LONG TERM CARE FACILITIES
  LTC3  017   RURAL HEALTH SWING BEDS
  LTC4  065   LONG TERM CARE FACILITIES FOR PEDIATRAIC SUBACUTE
         CARE
  LTC7  017   SUB-ACUTE (Adult) LONG TERM CARE FACILITIES
```

PROVIDER
```
ACCRONYM  TYPE  NAME OF PROVIDER TYPE

  LTM  017   LTC FACILITIES - ONLY TITLE 19-EFF. AFTER OBRA 10-90
  LTP  065   LTC PEDIATRIC SUBACUTE
  LTT  017   LTC FACILITIES - TRANSITIONAL CARE
  LTX  017   DISTINCT PART LTC FACILITIES
  MIA   ANY  A SPECIAL PROVIDER TYPE, FOR COUNTY BILLING OF MIAs
  MIC  060   LIKE THE MIAs ABOVE, BUT FOR COUNTY CONTRACT FACIL.
  MSS  074   MULTIPURPOSE SENIOR SERVICES PROGRAM
  MTA000 030   MEDICAL TRANSPORT-AIR- OLD, NO REMAINING ACTIVE
  MTA0055 38   MEDICAL TRANSPORT-NEW EXCLUSIVE AIR TRANSPORT
```

MTE	030	MEDICAL TRANSPORT-GROUND, EMERGENCY
MTN	030	MEDICAL TRANSPORT-GROUND, NON-EMERGENCY
NMW	005	CERTIFIED NURSE MIDWIFE
NP	007	NURSE PRACTITIONERS (PEDIATRIC & FAMILY SERV.)
PA-PS	031	PSYCHOLOGISTS
PU-PZ	031	PSYCHOLOGISTS
PHA	024	PHARMACIES-PHARMISTISTS
PHB-C	024	PHARMACIES-HOSPITALS
PHD-F	024	PHARMACIES
PHX	024	PHARMACIES-OUT OF STATE
PIA	011	PRISON INDUSTRIES FABRICATING OPTICAL LAB
PT	025	PHYSICAL THERAPISTS
PSY	031	PSYCHOLOGISTS
PTX	031	PSYCHOLOGISTS
REH	046	REHABILITATION CLINICS
RHC	034	RURAL HEALTH MEDICAL CLINICS (no longer used)
RHM	035	RURAL HEALTH MEDICAL CLINICS
RN	018	NURSE ANESTHETISTS
RPE	037	REQUIRED PROFESSIONAL EXPERIENCE (for intern SP)
RT	056	RESPIRATORY CARE PRACTITIONER
SD	020	OPTOMETRISTS
SP	037	SPEECH THERAPISTS
SS	055	SCHOOL-LINKED SERVICES / LOCAL EDUCATION AGENCIES
SUR	044	SURGERY CLINICS
THP	075	TRIBAL HEALTH PLAN
TMT	030	OUT OF COUNTY MEDICAL TRANSPORTATION (12 providers)
TPY	026	OUT OF COUNTY PHYSICIANS
X	MANY	AN X IS ADDED TO THE NUMBER WHICH WOULD BE GENERATED FOR IN-STATE PROVIDERS. THE PROVIDER TYPE AND CATEGORY OF SERVICES ARE THE SAME AS FOR IN-STATE PROVIDERS - EXCEPT FOR ORTHOTIC & PROSTHETIC WHICH USES 'X' IN THE PROVIDER NUMBER-NOTE EXAMPLES BELOW. X CAN ALSO MEAN BORDER as in across the border.

ACCRONYM	PROVIDER TYPE	NAME OF PROVIDER TYPE
XB	027	PROSTHETISTS (in-state)
XBB	004	OUT OF STATE BLOOD BANK
XC	027	PROVIDER IS BOTH PROSTHETIC AND ORTHOTHOTIC
XDC	006	OUT OF STATE DOCTORS OF CHIROPACTICS
XDME	002	OUT OF STATE DURABLE MEDICAL EQUIPMENT
XHSP3	016	OUT OF STATE HOSPITALS - INPATIENT
XHSP4	015	OUT OF STATE HOSPITALS - OUTPATIENT
XPY	026	OUT OF STATE PHYSICIANS
XRO	028	OUT OF STATE PORTABLE X-RAY
XTHP	035	BORDER TRIBAL HEALTH PLAN
00A	026	PHYSICIANS (M.D.)
000A	026	PHYSICIANS (M.D.)
00AX	026	PHYSICIANS (OSTEOPATHS)
00C	026	PHYSICIANS (M.D.)
000C	026	PHYSICIANS (M.D.)
00G	026	PHYSICIANS (M.D.)

```
  000G  026   PHYSICIANS (M.D.)
  000E  027   PODIATRISTS (D.P.M.)
  00F  026   FOREIGN PHYSICIANS IN USA ON SPECIAL PERMIT
  000F  026   FOREIGN PHYSICIANS IN USA ON SPECIAL PERMIT
  0000F 026   FOREIGN PHYSICIANS IN USA ON SPECIAL PERMIT
```

M.2 OLD PROVIDER NUMBER NAMING ACRONYMS

Some of these numbers still exist from earlier times. Most were created under the 'BLUES'/MIO system from the 1970s. Some now contain as few as one provider.

```
   PROVIDER
ACCRONYM  TYPE  NAME OF PROVIDER TYPE

  ACX  032   CERTIFIED ACCUPUNTURISTS (only two remaining)
  DDX  012   DISPENSING OPTICIANS (only one remaining)
  DIA  042   CHRONIC DIALYSIS CENTER (only one remaining)
  DS   --   DENTAL DOCTORS (no longer used in the EDS system)
  EMP  047   EMPLOYER/EMPLOYEE CLINICS (not used at this time)
  FSS  MANY  NO ACTIVE PROVIDERS REMAINING
  FS0  MANY  OUT OF STATE (BORDER) PROVIDERS - MOSTLY PHYSICIANS
  FS0-4 MANY   (70 physicians; 3 ambulance; 2 labs; 1 pharmacy)
  GR   MANY  VARIOUS OTHER GROUPS - OLD NUMBERS ISSUED BY 'BLUES'
  GRX  098   NO ACTIVE PROVIDERS REMAINING
  HAD  013   HEARING AID DEVICES (only 15 remaining)
  RUR  061   COUNTY HOSP.-OUTPATIENT (only one still remaining)
  SNF  024   PHARMACIES - NEVER ANY PROVIDERS, ONLY TEST FILES
  USA  MANY  OUT OF STATE MISC. PROVIDERS (few remaining active)
  YYY  022   MEDICAL GROUPS
  ZZR0  016   COMMUNITY HOSPITALS - INPATIENT
  ZZR1  Mix   COMMUNITY CLINIC AND HOSPITAL MIX
  ZZR2  015   COMMUNITY HOSPITALS - OUTPATIENT - OUT OF STATE


  ZZR3  016   NO ACTIVE PROVIDERS REMAINING
  ZZR5  060   COUNTY HOSPITALS (No remaining active providers)
  ZZR52 090   OUT OF COUNTRY INPATIENT HOSPITALS (No active)
  ZZR55 017   LONG TERM CARE FACILITIES-(Only 27 active providers)
  ZZR56 016   COMMUNITY INPATIENT HOSPITALS (No active)
  ZZR6-9 MIX   NO ACTIVE PROVIDERS REMAINING
  ZZT0  017   LONG TERM CARE FACILITIES
  ZZT1-9 MIX   LTC, HOSPTIALS, OUT OF STATE, ETC.
  ZZW  060   L.A. WAIVER PROVIDERS
  ZZX  061   NO ACTIVE PROVIDERS REMAINING
  ZZZA-D MIX   NO ACTIVE PROVIDERS REMAINING
  ZZZP 022&926 CALIFORNIA UNIVERSITIES DEPARTMENTS AND PHYSICIANS
  ZZZ1-9 MANY  MIX OF PHY. GROUPS, INDIV. PHY., MED TRANS.,& OTHERS
```

BLUE CROSS AND BLUE SHIELD HISTORICAL PERSPECTIVE

BLUE CROSS enrolled hospitals ONLY, and only in Northern California, and utilized the same number (ZZR0) for both in and out patient services. At the transfer, this was kept as the inpatient code and caused the creation of a new number for outpatient codes (HSP4), with the ZZR numeric added BLUE SHIELD enrolled hospitals Southern California ONLY, and all other provider types statewide. Blue Shield utilized both inpatient as well as outpatient provider numbers and

both were kept (ZZT3=inpatient and ZZT4=outpatient). Blue Shield indiscriminately utilized ZZZ for all other provider types. USA was utilized for out-of-state.

APPENDIX R. PROVIDER TYPE CODES

DN Dentist for Encounter data files only
001 Adult Day Care Centers
002 Assistive device and medical equipment
003 Audiologists
004 Blood banks
005 Certified nurse midwife
006 Chiropractors
007 Certified pediatric nurse practitioner and certified family Nurse practitioner
008 Christian Science practitioners
009 Clinical laboratories
010 Group certified pediatric nurse practitioner and certified Family nurse practitioner
011 Fabricating optical laboratory
012 Dispensing opticians
013 Hearing aid dispensers
014 Home Health Agencies
015 Community hospital outpatient departments
016 Community hospital inpatient
017 Long Term Care
018 Certified Nurse anesthetists
019 Occupational Therapists
020 Optometrists
021 Orthotists
022 Physicians group
023 Optometric group
024 Pharmacies/pharmacist
025 Physical therapists
026 Physicians
027 Podiatrists
028 Portable X-ray laboratory
029 Prosthetics
030 Ground medical transportation
031 Psychologists
032 Certified acupuncturist
033 Genetic disease testing
034 LCSW Crossover Provider Only (before 11/98 34 was Rural Health Clinics)
035 Rural Health Clinics and Federally Qualified Health Centers (FQHCs)
037 Speech therapists
038 Air ambulance transportation services
039 Certified hospice service per [35 file edits] 4249
040 Free clinics
041 Community clinics

042 Chronic dialysis clinics
043 Multi-specialty clinics
044 Surgical clinics
045 Exempt from licensure clinics
046 Rehabilitation clinics
047 Employer/Employee clinic (not on the current CA-MMIS Table)
048 County clinics not associated with hospital
049 Birthing centers-Primary Care Clinic
050 Clinic-otherwise undesignated
051 Outpatient heroin detoxification center
052 Alternative Birth Centers-Specialty Clinics
053 Breast Cancer Early Detection Program
054 Expanded Access to Primary Care
055 Local education agency
056 Respiratory Care Practitioner
057 EPSDT Supplemental Services Provider
058 Health Access Program
059 Congregate Living Health Facilities with Type A licensure
060 County hospital inpatient
061 County hospital outpatient
062 Group Respiratory Care Practitioner
063 Licensed Building Contractors
064 Employment Agency
065 Pediatric Subacute Care-LTC
066 Personal Care Agency
067 RVNS Individual Nurse Providers
068 HCBC Benefit Provider
069 Professional Corporation
072 Mental Health Inpatient
073 AIDS waiver provider
074 Multi-Purpose Senior Services
075 Indian Health Services/Tribal Health Plan for '638' clinics
080 California children's service/Genetically Handicapped Person Program-Non-institutional
081 California children's service/Genetically Handicapped Person Program-Institutional
084 Independent Diagnostic Testing Facility x-over provider only
085 CNS –Clinical Nurse Specialist x-over provider only
090 Out of state
092 Residential Care Facilities for the Elderly (RCFE)
093 Care Coordinator (CCA)
095 Private Non-Profit Proprietary Agency

APPENDIX S. ROUTINE PRENATAL CARE CODES

These CPT-4 Procedure codes came from the DHS Pregnancy Monitoring System as of September 1998:

THESE CODES COVER DELIVERY, ANTEPARTUM AND POSTPARTUM FOR VAGINAL BIRTH CARE:

'59400' THRU '59410'
'59610' '59612' '59614'

THESE CODES COVER CESAREAN DELIVERY:

59500' THRU '59515'

THESE ARE ALL THE 'MATERNITY CARE AND DELIVERY' CODES:

'59000' THRU '59899'

THESE ARE THE DELIVERY CODES:

CPT-VAGINAL-DELIVERY-ONLY	'59409' '59612'.
CPT-VAGINAL-INCL-POSTPART	'59410' '59614'.
CPT-VAGINAL-DELIVERY-GLOBAL	'59400' '59610'.
CPT-C-SECT-DELIVERY-ONLY	'59514' '59620'.
CPT-C-SECT-INCL-POSTPART	'59515' '59622'.
CPT-C-SECT-DELIVERY-GLOBAL	'59510' '59618'.

HCPCS Local Procedure Codes also came from the PMS system:

THESE CODES COVER DELIVERY, ANTEPARTUM AND POSTPARTUM CARE THAT MATCH CPT4 CODES '59400' - '59410' AND CODES '59610' '59612' '59614':

'Z1032' THRU 'Z1038'

THESE CODES COVER POSTPARTUM VISITS.

'Z1004' 'Z1012' 'Z1026'

THESE CODES ARE CLINIC/BIRTHING CENTERS DELIVERY CODES:

'Z1002'
'Z1006'
'Z1010'
'Z1014'
'Z1024'

THIS CODE IS FOR A BIRTHING ROOM:
'Z7516'

APPENDIX T. RURAL HEALTH BILLING PROCEDURE CODES

RHC and FQHC facilities use the following all-inclusive per visit codes:

RHC and FQHC: All Inclusive Per Visit Codes.

Code	Description	Explanation	Program
01	Medi-Cal Per Visit Code	Requires medical justification for more than one visit per recipient per day. For recipients in Medi-Cal managed care plans, see codes 11 – 17.	RHC, FQHC
02	Crossover Claims	Requires the Medicare EOMB/MRN/RA be attached to the claim. A deductible is not included in the crossover reimbursement. Do not complete *Condition Codes* fields (Boxes 24 – 30) for Medicare status.	RHC, FQHC
03	Dental Services	Requires a pregnancy-related primary or secondary ICD-9 diagnosis code of 640 – 648.9, 651 – 658.9, 659.4 – 659.9, V22 – V23.9, V28.0 – V28.9 or V61.5 – V61.6 when billing for dental services rendered to a pregnant recipient eligible under aid code **0U, 0V, 3T, 3V**, 44, 48, 5F, **5J, 5R, 5T, 5W, 55**, 58, **6U, 7C, 7G, 7K, 7N or 8T**.	RHC, FQHC
04	Optometry Services		RHC, FQHC
06	ADHC Regular Day of Service	Minimum four-hour day at the center excluding transportation time. Prior authorization is required. Refer to the *Adult Day Health Care (ADHC) Centers* section in the Part 2 manual, *Outpatient Services for Adult Day Health Care (ADHC) Centers.*	RHC, FQHC
07	ADHC Initial Assessment Day	With subsequent attendance at the center. Limit of three assessment days. Same center may not bill for assessment days again within 12 months of the last day of service. If the participant transfers to another center, assessment days may be billed by the second center without the 12-month restriction.	RHC, FQHC
08	ADHC Initial Assessment Day	Without subsequent attendance at the center. A statement explaining why the participant did not attend the center subsequent to assessment must be entered in the *Remarks* area of the claim (same limitations as for code 07).	RHC, FQHC
09	ADHC Transition Day	Limit of five days per participant's lifetime. A statement that the *Physician Authorization and Medical Information* form is on file at the center must be entered in the *Remarks* area of the claim.	RHC, FQHC

RHC and FQHC: Services Not Covered by Recipient's Managed Care Plan: RHC and FQHC facilities use the following per-visit codes to bill for services rendered to Medi-Cal managed care plan recipients when the services are not covered by the plan.

Code	Description	Explanation	Program
11	Licensed Clinical Social Worker (LCSW)	A mental health service rendered by a LCSW for recipients of any age.	RHC, FQHC
12	Psychologist	A mental health service rendered by a psychologist for recipients of any age.	RHC, FQHC

Updated:

Code	Description	Explanation	Program
13	Psychiatrist	A mental health service rendered by a psychiatrist for recipients of any age.	RHC, FQHC
15	Acupuncture	An acupuncture service rendered for recipients of any age, if the acupuncturist is a doctor of medicine.	RHC, FQHC
16	Chiropractic	A chiropractic service rendered for recipients of any age, if the practitioner is authorized to practice chiropractics.	RHC, FQHC
17	Heroin Detox	A heroin detox service rendered in accordance with *California Code of Regulations*, Sections 51239, 51328 and 51533, if the physician is a doctor of medicine who examines, diagnoses and prescribes treatment for a patient enrolled in a heroin detox program.	RHC, FQHC

RHC and FQHC: Services for Recipients Enrolled in a Managed Care Plan: RHC and FQHC facilities use the following code when billing for services rendered to enrollees of a Medi-Cal managed care plan and the service is covered by the plan. Only providers in select counties may use this code, per Department of Health Services (DHS) instructions.

Code	Description	Explanation	Program
18	Managed Care Differential Rate	FQHC services covered by managed care and rendered to recipients enrolled in Medi-Cal managed care plans. The rate for this code approximates the difference between payments received from the managed care plan(s), rendered on a per visit basis and the Prospective Payment System (PPS) rate. The current billing requirement or code 01 will apply when code 18 is billed. Refer to *Figure 1* in the *Rural Health Clinics (RHC) and Federally Qualified Health Centers (FCHC) Billing Example* section in this manual.	RHC, FQHC

Under the Prospective Payment Plan (PPS), cost reports are not required. An annual revenue reconciliation is made by Audits and Investigations Audits and Investigations staff to equalize the difference between reimbursements from managed care plans and providers' PPS rates.

Per-visit code 18 rate is adjusted on an annual basis, if necessary. Audits and Investigations sends forms for annual distribution to each RHC and FQHC to facilitate this reconciliation.

APPENDIX U. SHORT-DOYLE/MEDI-CAL CODES

Q.1 SD/MC PROCEDURE CODES

Short-Doyle/Medi-Cal claims are for mental health services and alcohol and drug services. Department of Mental Health (DMH) and the Department of Drug and Alcohol Program (ADP) contract with Department of Health Services to do their claims processing. They are processed by program MFR151 to convert the 350-character record into a single segment paid claim after the MSD system adjudicates the claims.

Four-digit codes came into effect beginning with the April 1992 month of payment. The first character is either a 0 or a 5. A 5 means that record is from a case management claim (Mode of Service code = '50'). A 0 means all non-case management claims. The second digit is the first character of the MSD system's Service Function code. They are listed further down. The last two digits reflect the Program Code with is '01' for Mental Health; '10' for Alcohol Services;' '20' for Drug Services (formerly '05'); and '25' for Prenatal Services. And starting with the July 1999 claims, the last character of the Service Function code is moved into the fifth/last character of the procedure code. Before the fifth/last character of the procedure code was a space.

The codes and/or definitions went into effect beginning with the July 1992 month of service due to the implementation of the Mental Health Rehabilitation Option. The codes were defined as follows:

0001 - Mental Health-Case Management
0101 - Mental Health-Collateral, Assessment, Individual Therapy, or Group Therapy (combines former codes of 0101, 0301, 0401, and 0501)
0201 - Mental Health-Crisis Stabilization-Emergency room, Crisis Stabilization, Psychiatric Health Facility
0220 - Drug Services-Methadone Maintenance
0225 - Prenatal Services-Methadone Maintenance
0301 - Same as 0101 (optional code)
0310 - Alcohol Services-Day Care Habilitative
0320 - Drug Services-Day Care Habilitative
0325 - Prenatal Services-Day Care Habilitative
0401 - Same as 0101 (optional code)
0425 - Prenatal Services-Residential Care
0501 - Same as 0101 (optional code)
0520 - Drug Services-Naltrexone Treatment
0525 - Prenatal Services-Naltrexone Treatment
0601 - Mental Health-Medication Support
0701 - Mental Health-Crisis Intervention
0801 - Mental Health-Day Treatment Intensive
0810 - Alcohol Services-Drug Free Treatment
0820 - Drug Services-Drug Free Treatment
0825 - Prenatal Services-Drug Free Treatment
0901 - Mental Health-Day Treatment Rehabilitative
5101 - Mental Health-Case Management/Brokerage

Q.3 SD/MC MODE OF SERVICE (ACCOMMODATION CODES)

On Short-Doyle/Medi-Cal claims, the Mode of Service Code is the equivalent of the accommodation code. So, therefore, it is moved into the accommodation code in the paid claims segment. ADP only uses Mode of Service of 12 and 17 since they offer no inpatient services. DMH uses all of the Modes of Service codes. They are defined as follows:
DMH Only
05 - Residential Rehabilitative Treatment

07 - Inpatient Hospital Services
08 - Psychiatric Hospital Inpatient (HIP)-Age under 21
09 - Psychiatric HIP-Age 65+
DMH and ADP
12 - Outpatient Hospital Services
ADP Only
17 - Clinic Services
18 - Non-Residential Rehabilitative Treatment

Q.4 SD/MC SERVICE FUNCTION CODES

ADP – one of the following codes

20 through 22	Outpatient Methadone Maintenance
23 through 25	LAAM Maintenance1
26 through 27	NTP – Individual Counseling
28 through 29	NTP – Group Counseling
30 through 39	Day Care Habilitative (counseling included)
40 through 49	Residential Care (counseling included)2
50 through 59	Naltrexone Treatment (NAL)3(d)
80 through 84	Outpatient Drug Free – Individual Counseling
85 through 89	Outpatient Drug Free – Group Counseling

DMH – one of the following codes

24 Hour Services (Cost Reporting Mode 05, M/C Mode 05,07,08,09)

10 through 18	Local Hospital Inpatient
19	Hospital Administrative Days
20 through 29	Psychiatric Health Facility
40 through 49	Adult Crisis Residential
65 through 79	Adult Residential

DAY SERVICES (COST REPORTING MODE 10, M/C MODES 12 OR 18))

20 through 24	Crisis Stabilization – Emergency Room
25 through 29	Crisis Stabilization – Urgent Care
81 through 84	Day Treatment Intensive – Half Day
85 through 89	Day Treatment Intensive – Full Day
91 through 94	Day Rehabilitation – Half Day
95 through 99	Day Rehabilitation – Full Day

OUTPATIENT SERVICES (COST REPORTING MODE 15, M/C MODES 12 OR 18)

01 through 09	Case Management/Brokerage
10 through 18	Mental Health Service (MHS)
19	MHS Professional Inpatient Visit
30 through 38	Mental Health Service
39	MHS Professional Inpatient Visit
40 through 48	Mental Health Service
49	MHS Professional Inpatient visit
50 through 57	Mental Health Service
58	Therapeutic Behavioral Services (TBS)
59	MHS Professional Inpatient Visit

[1] LAAM is not valid for Program Code 25 (Perinatal Services).
[2] Residential is not valid for Program Code 20.
[3] NAL is not valid for Program Code 25. NTP – Narcotic Treatment Program. SF codes 20–25 can only use counseling SF codes 26-29.

60 through 68	Medication Support
69	Medication Support Professional Inpatient visit
70 through 78	Crisis Intervention (CI)
79	Crisis Intervention Professional Inpatient Visit

APPENDIX V. VENDOR CODES

VENDOR CODE	PROVIDERS
01	Adult Day Health Care Center
02	Medicare Crossover Provider Only
03	CCS/GHPP Program
04	Genetic Disease Testing
05	Certified Nurse Midwife
06	Certified Hospice Service
07	Certified Pediatric Nurse Practitioner
08	Certified Family NP
09	Respiratory Care Practitioner
10	Licensed Midwife Program
11	Fabricating Optical Lab
12	Optometric Group
13	Nurse Anesthetist
14	Early Access to Primary Care
19	Portable X-ray Lab
20	Physician (M.D. or D.O.)
21	Ophthalmologist (San Joaquin Foundation only)
22	Physicians Group
23	Lay Owned Lab Services(RHF)
24	Clinical Lab
26	Pharmacies
27	Dentist
28	Optometrist
29	Dispensing Optician
30	Chiropractor
31	Psychologist
32	Podiatrist
33	Acupuncturist
34	Physical Therapist
35	Occupational Therapist
36	Speech Therapist
37	Audiologist
38	Prosthetist
39	Orthotist
40	Other Provider (non-professional provider services)
41	Blood Bank
42	Medically Required Trans
44	Home Health Agency
45	Hearing Aid Dispenser
47	Intermediate Care Facility – Developmentally Disabled
49	Birthing Center
50	County Hospital - Acute Inpatient
51	County Hospital - Extended Care
52	County Hospital - Outpatient
53	Breast Cancer Early Detection Program
55	Local Education Agency
56	State Developmental Centers (formerly State Hosp-Developmentally Disabled)
57	State Hospital-Mentally Disabled
58	County Hospital - Hemodialysis Center

59	County Hospital – Rehab Facility
60	Community Hospital - Acute Inpatient
61	Community Hospital - Extended Care
62	Community Hospital - Outpatient
63	** Mental Health Inpatient Consolidation
64	** Short-Doyle Community Mental Health-Hosp Services
68	Community Hospital - Renal Dialysis Center
69	Community Hospital - Rehab Facility
70	* Acute Psychiatric Hospital
71	Home/Comm Based Service Waivers
72	Surgicenter
73	AIDS Waiver Services
74	** Short-Doyle Community Mental Health-Clinic Svs
75	Organized Outpatient Clinic
76	** DDS Waiver Services
77	Rural Health Clinics/FQHCs/Indian Health Clinics
78	Community Hemodialysis Center
79	Independent Rehabilitation Facility
80	Nursing Facility (formerly known as Skilled Nursing Facility)
81	MSSP Waiver Services
82	EPDST Supplemental Services
83	Pediatric Subacute Rehab/Weaning
84	Assist. Living Waiver Pilot Project (ALWPP)
88	Self-Directed Services (SDS) Waiver Services
89	** Personal Care Services Program (In Home Supportive Services)
90	Out of State
91	Outpatient Heroin Detoxification
92	Medi-Cal Targeted Case Management
93	** DDS Targeted Case Management
94	CHDP Provider
95	** Short-Doyle Community Mental Health-Rehabilitation Treatment)
All Other	All Other Providers

* Vendor Code 70 was assigned but never implemented.
** These are Medi-Cal services but files are separate from regular Medi-Cal claims files.

NOTE: Prior to 11/1/92, Vendor Code 07 meant Certified Nurse Practitioner for a pilot project for which there were very few claims. Vendor Code 49 was used by Redwood Health Foundation (Plan Code 3) from September 1973 through June 1989 when RHF went out of business. The code meant out-of-state/unassigned.

APPENDIX W. INDEX

Year To Date, 322	YTD, 322

APPENDIX X. GLOSSARY

If you have an Id at HWDC you can find abbreviations on line! The data set name is: HD.PAIDCLM.DHS.ABBREVS.

There is a list of more than 800 abbreviations that the Department of Health Care Services (DHCS) uses! There is instructions on how to find on just the abbreviation you are searching for.

ADP	Department of Alcohol and Drugs Programs
AEVS	Automatic Eligibility Verification System
AFDC	Aid to Families with Dependent Children
AFDC	Aid to Financially Dependent Corporations
AFDC-MN	Aid to Families with Dependent Children--Medically Needy
AFLP	Adolescent Family Life (Pregnant Teen) Program
AFP	Alpha Fetal Protein testing (done at DHCS's Berkeley labs)
AHF	Anti-Hemophilia Factors
AHS	Alternative Health Systems
AIDS	Acquired Immune Deficiency Syndrome
AIM	Access for Infants and Mothers
AKA	Also Known As (Expert Witness)
AN	Action Notice
ANEC	Abused, Neglected, or Exploited Children
APD	Advance Planning Document
APP	Aid Paid Pending
APPR	Average Private Pay Rate (for Nursing facility services)
APSB	Aid to Potentially Self-Supporting Blind
AR	Authorized Representative (for Medi-Cal Beneficiary(form MC360))
ARC	AIDS Relations Complex (or AIDS Related Conditions)
ARDS	Automated Remittance Data Service
ARF	Action Request File
ASCII	American Standard Code for Information Exchange (7-bit + parity)
ASR	Approved Services Report (Dams report from MSD)
ATD	Aid To Disabled
AU	Assistance Unit (AFDC)
BabyCal	Medi-Cal for babies
BBA	Balanced Budget Act
BCEDP	Breast Cancer Early Detection Program
BCP	Budget Change Proposal
BCP	Breast Cancer Program
BEER	Beneficiary Earnings Exchange Record
BENDEX	Beneficiary Data Exchange
BENE	Beneficiary
BENE ID	Beneficiary ID number
BEOMB	Beneficiary Explanation Of Medi-Cal Benefits
BHI	Boarding Homes and Institutions
BIC	Benefit Identification Card
BID	Beneficiary ID number
BLS	Basic Life Support
BPI	Business Process Improvement
BPST	Billing Process System Testing
BSU	Billing Support Unit
BUR	Beneficiary Utilization Review
C	Children under 21
CA	California
CAAP	California Alternative Assistance Program

CACI	Change Assessment, Control and Implementation
CAHF	California Association of Health Facilities
CalOPTIMA	Cal. Orange Prevention and Treatment Integrated Medical Plan
CalWORKS	California Work Opportunity and Responsibility to Kids Plan
CALPOS	California Point of Sale (for Pharmacy claims processing)
CA-MMIS	California Medicaid Management Information System
CAT	Computerized Axial Tomography (same as CT)
CATS	Common Application Transaction System
CBA/IP	Cost Benefit Analysis/Implementation Plans
CBO	Community Based Organization
CBC	Complete Blood Count
CBDMP	California Birth Defects Monitoring Program
CBC	California Birth Certificates
CC	Cost Center
CCLHO	California Conference of Local Health Officers
CCN	Claim Control Number
CCR	California Code of Regulations
CCS	California Children Services
CCU	Critical Care Unit
CDA	California Department of Aging
CDB	Central Data Base
CDMMIS	California Dental Medicaid Management Information System
CDL	California Driver's License
CDR	Claims Detail Request
CDR	Claims Detail Report
CDS	California Dental Services
CEC	Continuing Eligibility for Children
CERTS	Claims and Eligibility Real-Time System
CETA	Comprehensive Employment and Training Act
CFNP	Certified Family Nurse Practitioner
CFR	Code of Federal Regulations
CHAMPUS	Civilian Health and Medical Program of the Uniform Services
CHDP	Child Health and Disability Prevention Program
CHDTP	Child Health, Disability and Treatment Program
CHFC	California Health Facilities Commission
CHI	California Health Initiative
CHIC	California Health Identification Card
CHIPP	California Health Information Planning Project
CHS	Center for Health Statistics
CHS	Capitated Health Services
CI	Cochlear Implant
CICS	Customer Information Control System (MEDS is a CICS application)
CID	Central Issuance of ID Cards
CIF	Claims Inquiry Forms
CIN	Client Index Number (newer definition of CIN)
CIN	California Identification Number (original definition of CIN)
CLHF	Congregate Living Health Facilities
CLIA	Clinical Laboratory Improvement Amendments of 1988
CMAC	California Medi-Cal Assistance Commission
CMAG	County Meds Advisory Group
CMC	Computer Media Claims
CMD	Computer Media Document
CMP	Competitive Medical Plans
CMIS	Contract Management Information System
CMIPS	Case Management, Information and Payrolling System
CMS	Children Medical Services

CMSP	County Medical Services Program
CNM	Certified Nurse Midwife
CNST	Children Not in School or Training
COB	Close Of Business
COBRA	Consolidated Omnibus Budget Reconciliation Act
COHS	County Operated Health Systems
COLA	Cost Of Living Allowance
COS	Category of Service
CP	Confirmed Pregnancy
CP	Continental Plaza (DHCS's building on North 7th Street in Sac.)
CPNP	Certified Pediatric Nurse Practitioners
CPSP	Comprehensive Prenatal Services Program
CPT-4	Current Procedure Terminology, Fourth Edition
CPU	Central Processing Unit
CRNA	Certified Registered Nurse Anesthetist
CRP	Cuban Refugee Program
CRT	Cathode Ray Tube
CRVS	California Relative Value Studies
CS	Change Support
CSC	Computer Sciences Corporation
CSN	California Standard Nomenclature (now called CPT)
CSIU	Case Screening and Investigation Unit
CT	Computerized Tomography (same as CAT)
CTP	Children's Treatment Program (Formerly CHDTP before 8/94)
CVSO	County Veterans Service Offices
CWD	County Welfare Department
CWDA	County Welfare Directors Association
CWO	County Welfare Office
CWS	Child Welfare System
D & C	Dilation and Curettage
DACON	Daily Consumption (of pharmacy products)
DA/FSO	District Attorney/Family Support Office
DA&A	Drug Addiction and/or Alcoholism
DAC	Disabled Adult Child
DAEVS	Digital Automated Eligibility Verification System
DASD	Direct Access Storage Device
DB2	Database 2 (an IBM relational data base language)
DBP	Department of Benefit Payments (now DSS)
DCD	Data Correlation and Documentation System
DCMS	Data Center Management System
DD	Data Definition
DD	Developmentally Disability
DD-H	Developmentally Disability--Habilitative
DD-N	Developmentally Disability--Nursing
DDE	Direct Data Entry
DDH	Developmentally Disability--Habilitative
DDN	Developmentally Disability--Nursing
DDS	Department of Developmental Services
DDS	Doctor of Dental Surgery
DED	Disability Evaluation Division
DED	Data Element Dictionary
DEFRA	Deficit Reduction Act
DELTA	Delta Dental Services
DGS	Department of General Services
DHHS	Department of Health and Human Services (Federal)
DHCS	Department of Health Care Services

DI	Disability Insurance
DIB	Disability Insurance Benefits
DME	Durable Medical Equipment
DMH	Department of Mental Health
DOB	Date Of Birth
DOF	Department of Finance
DOH	Department of Health
DOJ	Department of Justice
DOP	Date of Payment
DOS	Date of Service
DOS	Disk Operating System
DOSE	Dosage Form (part of the Smart Key)
DOT	Directly Observed Therapy (for TB program patients)
DP	Data Processing
DP	Dialysis only Program
DP/NF	Distinct Part/Nursing Facility
DPA	Durable Powers of Attorney
DPAHC	Durable Powers of Attorney for Health Care
DPAP	Durable Powers of Attorney for Property Management
DPO	Discharge Planning Option
DPT	Discharge Planning TAR
DPVP	Direct Purchase Vaccine Program
DRA	Disaster Recovery Action
DSB	Data Systems Branch
DSP	Dialysis Supplement Program
DSS	Department of Social Services
DTP	Diphtheria, Tetanus, Pertussis
DUR	Drug Utilization Review
DUR	Drug Use Review
DX	Diagnosis
E & M	Evaluation and Management (procedures)
EA	Emergency Assistance
EAPC	Expanded Access to Primary Care
EA-UP	Emergency Assistance--Unemployed Parent
EBCDIC	Extended Binary-Coded Decimal Interchange Code (8-bit)
EBS	Electronic Billing System
EC	Eligibility Counter
ECA	Entrant Cash Assistance
ECF	Extended Care Facility
ECG	Electrocardiogram
ECS	Earning Clearance System
EDC	Estimated Date of Confinement (approximate date pregnancy ends)
EDD	Employment Development Department
EDI	Electronic Data Interchange
EDP	Electronic Data Processing
EDS	Electronic Data Systems
EEO	Equal Employment Opportunity
EFDP	Early Fraud Detection Program
EFT	Electronic Fund Transfer
EHF	Eligibility History File
EGHP	Employer Group Health Plan
EKG	Electrocardiogram
EMA	Entrant Medical Assistance
EMC2/TAO	Electronic Mail Communications Center/Totally Automated Office
EOB	Explanation Of Benefits
EOMB	Explanation Of Medicare Benefits

EPSDT	Early Periodic Screening, Diagnosis and Treatment
ESAC	Eligibility Status Action Code
ESC	Eligibility Status Code
ESWL	Extracorporeal Shock Wave Lithotripsy
EVC	Eligibility Verification Confirmation
EVC	Eligibility Verification Control
EW	Eligibility Worker
FAC	Federal Allowable Cost (Drugs)
FAME	Fiscal intermediary Access to Medi-Cal Eligibility
FBR	Federal Benefit Rate
FBU	Family Budget Unit (part of the Beneficiary Id number)
FC	Foster Care
FDA	Food and Drug Administration
FDB	Food and Drug Branch (within DHCS)
FFP	Federal Financial Participation
FFS	Fee For Service
FG	Family Group
FHC	Federally Qualified Health Centers
FHOP	Family Health Outcomes Project
FI	Fiscal Intermediary
FIMD	Fiscal Intermediary Management Division
FMAP	Federal Medical Assistance Percentage (matching Fed funds %)
FNS	Food and Nutrition Service (federal)
FO	Field Office
FPACT	Family P.A.C.T. (Planning Access Care & Treatment)
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FS	Food Stamp Program
FS/NF	Free-Standing/Nursing Facility
FSD	Family Support Division
FSR	Feasibility Study Report
FTB	Franchise Tax Board
FY	Fiscal Year
GA	General Assistance
GAC	General Acute Care
GACH	General Acute Care Hospital
GAIN	Greater Avenues for Independence Program
GAL	Global Address List (used by OUTLOOK for E-mail)
GHPP	Genetic Handicapped People Program
GIS	Geographic Information Systems
GMC	Geographic Managed Care
GOSHN	Governor's Office Special Hospital Negotiator
GR	General Relief
GTC	Generic Therapeutic Class (part of the Smart Key)
GYN	Gynecology
HAP	Health Access Programs
HCBS	Home and Community Based Services
HCDF	Health Care Deposit Fund
HCFA	Health Care Financing Administration
HCP	Health Care Plans
HCPCS HCFA	Common Procedure Coding System
HCPP	Health Care Prepayment Plans
HDU	Health Demographics Unit
HF	Healthy Families
HFAV	Healthy Families Administrative Vendor
HFPA	Hospital Facility Planning Area

HHA	Home Health Agency
HHS	Home and Human Services
HI	Health Initiative
HIC	Health Insurance Claim
HIC-NO	Medicare HIC Number
HICL	Hierarchical Ingredient Code List/Generic Name (part of the Smart Key)
HIIU	Health Insurance Identification Unit
HIO	Health Insuring Organization
HIP	Hospital In Patient
HIPAA	Health Insurance Portability and Accountability Act
HIPD	Health Insurance Payment Demand
HIPP	Health Insurance Premium Payment
HIS	Health Insurance System
HIU	Health Insurance Unit
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HMS	Health Management Systems
HOP	Hospital Out Patient
HPSM	Health Plan of San Mateo
HRI	Health Related Industries
HSA	Health Service Area
HWDC	Health and Welfare Data Center
I/O	Inpatient/Outpatient
I/O	Input/Output
ICD	International Classification of Diseases (diagnosis code)
ICDA	International Classification of Diseases, Adapted
ICDA	International Classification of Diseases, Adapted
IDTF	Independent Diagnostic Testing Facility
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICN	Internal Control Number
ICU	Intensive Care Unit
IDMS	Integrated Data Management System
IE	Ineligible (SOC aid code for MEDS and SOC database)
IEVS	Income and Eligibility Verification System
IFD	Integrated Earnings Clearance/Fraud Detection System
IHMC	In Home Medical Care
IHSS	In Home Supportive Services
IMAP	Information Management Annual Plan
IMD	Institutions for Mental Diseases
INA	Immigration and Nationality Act of 1990
INS	Immigration and Naturalization Services (Federal)
IPL	Initial Program Load
IPP	Individual Program Plan
IRCA	Immigration Reform and Control Act (became law in 1986)
IRS	Internal Revenue Service (Federal)
IS	Information System
ISAWS	Interim Statewide Automated Welfare System
ISIS	Integrated Statewide Information System for WIC
ISM	In-Kind Support and Maintenance
IT	Information Technology
IVR	Interactive Voice Response
IZ	Immunization System
JAD	Joint Application Design
JCL	Job Control Language
KDE	Key Data Entry

LAN	Local Area Network
L&C	Licensing and Certification
LCSW	Licensed Clinical Social Worker
LEA	Local Education Authority
LEADER	Los Angeles Eligibility Automated Determination Evaluation Report
LHD	Local Health Directors
LMW	Licensed Midwife
LOA	Letter Of Authorization
LPC	Long Paid Claims
LPR	Lawful Permanent Resident (under IRCA of 1986)
LTC	Long Term Care
LTR	Lawful Temporary Resident
LTNG	Long Term Non grant Status
MAC	Maximum Allowable Cost
MAIC	Maximum Allowable Ingredient Cost
MAO	Medi-Cal Assistance Only
MAPC	Maximum Allowable Product Cost (for Medical Supplies list)
MAR	Management Administrative Reports
MARS	Management and Administrative Report System
MBU	Medi-Cal Family Budget Unit
MCN	Managed Care Network
MC	Medi-Cal
MC-177	Record of Health Care Costs Document (form number)
MCC	Medi-Cal for Children
MCCA	Medicare Catastrophic Coverage Act
MCE	Medical Care Evaluation
MCH	Maternal and Child Health Branch of DHCS
MCN	Managed Care Network
MCO	Medi-Cal Only
MCOD	Medi-Cal Operations Division
MCP	Managed Care Plan
MCPP	Medi-Cal Procurement Project
MCPD	Medi-Cal Policy Division
MCR	Medicare
MDL	Microbial Disease Laboratory
MDS	Minimum Data Set (for nursing home resident assessment and care)
MEB	Medi-Cal Eligibility Branch
MEM	Medi-Cal Eligibility Manual
MEDS	Medi-Cal Eligibility Data System
MEDS ID	MEDS ID is a unique identifier and can be a SSN or Pseudo SSN
MEF	MEDS Extract File
MFBU	Medi-Cal Family Budget Unit
MFG	Manufacturer
MFR	Medi-Cal Federal Reporting System
MHP	Mental Health Plan
MI	Medically Indigent
MIA	Medically Indigent Adult
MIC	Medically Indigent Children (no longer in use)
MIO	Medi-Cal Intermediary Operations
MIS	Management Information System
MMC	Medi-Cal Managed Care
MMCEB	Medi-Cal Managed Care Expansion Branch
MDR	Medi-Cal Drug Reporting (system)
MMCD	Medi-Cal Managed Care Division
MMEF	MEDS Monthly Extract File (same as MEF)
MMIS	Medicaid Management Information System

MN	Medically Needy
MNO	Medically Needy-Only
MOE	Month Of Eligibility
MOP	Month Of Payment
MOPI	MEDS Online POS (Point of Service) Inquiry
MOS	Month Of Service
MQT	Medicaid Qualifying Trust
MPI	Medical Public Inquiry
MPS	Medi-Cal Provider Software
MR	Mental Retardation
MRB	Medical Review Branch
MRI	Magnetic Resonance Imaging
MRMIB	Managed Risk Medical Insurance Board
MRN	Medicare Remittance Notice (replaces the EOMB form)
MRMIP	Major Risk Medical Insurance Program
MSD	Medi-Cal Short Doyle
MSSP	Multipurpose Senior Services Program
MTS	Medi-Cal Transaction Software
MTE	Medical Transportation/Emergency
MTR	Medi-Cal expenditures and Treatment Reporting system
NAFS	Non-Assistance Food Stamps
NARD	National Association of Retail Druggists
NBC	Normal Birthing Center
NCPDP	National Council Prescription Drug Program (reject codes)
NDI	Non-Industrial Disability Insurance (State)
NDC	National Drug Code
NDDF	National Drug Data File(TM)
NDM	Network Data Mover (sends IEVS request files to Baltimore)
NF	Nursing Facility
NF	Nursing Facility Level A = Intermediate Care Facility
NF	Nursing Facility Level B = Skilled Nursing Facility
NICU	Neonatal/Newborn Intensive Care Unit
NMP	Non-Physician Medical Practitioner
NOA	Notice of Action
NP	Nurse Practitioner
NPI	National Provider Identifier
NHSP	Newborn Hearing Screening Program Other PA Other Public Assistance
OB	Obstetrics
O/C	Other Coverage
O&P	Orthotic and Prosthetic
OAG	Office of Auditor General
OAS	Old Age Security
OASDI	Old Age, Survivors and Disability Insurance
OB	Obstetrics
OB8	Office Building #8 (DSS's building at 714 P St. in Sacramento)
OB9	Office Building #9 (DHCS's building at 744 P St. in Sacramento)
OBRA	Omnibus Budget Reconciliation Act
OC	Other Coverage
OCC	Out-of-County-Care
OCCS	Out-of-County-Care Service
OCHS	Office of County Health Services
OCR	Optical Character Recognition
OCS	Other Coverage Section (part of PSD's Recovery Branch)
OFP	Office of Family Planning
OHC	Other Health Care coverage code
OIG	Office of Inspector General

OIL	Operating Instruction Letter
OIT	Office of Information Technology
OMCC	Office of Managed Care Coordination
OPTIMA	Orange Prevention & Treatment Integrated Medical Assistance Plan (CalOPTIMA is Orange county's full name for the Health Initiative
ORR	Office of Refugee Resettlement
OSHPD	Office of Statewide Health Planning and Development
OUCH	Occupational Urgent Care Health Services
OV	Office Vision (=PROFS)
PA	Physician Assistant
PA	Public Assistance
PACT	Planning Access Care & Treatment
PANVALET	Program Management System
PAS	Pre-Admission Screening
PASARR	Pre-Admission Screening and Annual Resident Review
PC	Personal Computer
PC	Professional Component
PCCM	Primary Care Case Management
PCFH	Primary Care and Family Health
PCG	Prenatal Care Guidance Program
PCPP	Primary Care Provider Program
PCSP	Personal Care Services Program
PD	Presumptive Disability (for babies born < 37 wks or < 2lb 10 oz)
PDHC	Pediatric Day Health Care (for medically fragile kids 2/2000)
PE	Presumptive Eligibility (of pregnant women)
PE	Personnel Equivalent
PET	Positron Emission Tomography
PEU	Provider Enrollment Unit
PFT	Pulmonary Function Tests
PHF	Public Health Facility
PHP	Prepaid Health Plan
PHRED	Prepaid Health Research, Evaluation, and Demonstration
PIA	Prison Industry Authority
PIC	Picture (used in COBOL programs to define alphanumeric fields)
PIN	Personal Identification Number
PIN	Provider Identification Number
PIR	Post Implementation Review
PL	Public Law (Federal)
PLTCCM	Primary Long Term Care Case Management
PMF	Provider Master File(from EDS)
PMIF	Pooled Money Investment Fund
POE	Proof of Eligibility
POS	Place of Service
POS	Point of Sale (for Pharmacy claims processing)
POS	Point of Service
PPM	Physicians Performed Microscopy
PPU	Premium Payment Unit
PROFS	Professional Office System (also called Office Vision)
PRP	Private Resettlement Program
PRUCOL	Permanently Residing Under the Color of Law
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act
PS	Package Size (part of the Smart Key)
PSC	Provider Support Center
PTN	Provider Telecommunications Network
PUBS	Percutaneous Umbilical Blood Sampling
PVS	Payment Verification System

PWE	Principal Wage Earner
QA	Quality Assurance
QDWI	Qualified Disabled Working Individual
QI	Qualified Individual
QI	Quality Improvement
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice (EDS forms)
RAD	Remittance Advice Details (replaces RA for LTC, In & Outpatient)
RACF	Resource Access Control Facility
RAW	Replacement Agricultural Worker
RCA	Refugee Case Assistance
RD	Renal Dialysis
RDP	Refugee Demonstration Project
RDW	Record Descriptor Word
REHF	Recipient Eligibility History File - replaced by FAME
REI	Recognition Equipment, Inc. (EDS OCR equipment)
REOMB	Recipient Explanation of Medi-Cal Benefits
RF	Reference File (Like RFF035)
RFP	Request For Proposal
RG	Refused Grant
RHC	Rural Health Clinics
RHF	Redwood Health Foundations (ended 06/30/91)
RJE	Remote Job Entry
RMA	Refugee Medical Assistance
RR	Responsible Relative (SOC aid code for MEDS and SOC database)
RRB	Railroad Retirement Board Number
RRP	Refugee Resettlement Program
RSDI	Retirement, Survivors, and Disability Income
RTD	Resubmission Turnaround Document
RVS	Related Values Studies
S & I	Suspended and Ineligible
SACSS	Statewide Automated Child Support System
SAM	State Administrative Manual
SAVE	Systematic Alien Verification for Entitlements
SAW	Special Agricultural Worker
SAWS	Statewide Automated Welfare System
SBHI	Santa Barbara Health Initiative
SC	Special Circumstances
SCCHO	Santa Cruz County Health Options
SCI	State Client Index
SCO	State Controller's Office
SCPHMCN	Sonoma County Partners for Health Managed Care Network (1/1/97)
SD	Short Doyle
SD/MC	Short-Doyle/Medi-Cal
SDI	State Disability Insurance
SDHS	State Department of Health Services
SDN	System Development Notice
SDSS	State Department of Social Services
SDX	State Data Exchange
SED	Seriously Emotionally Disturbed
SFD	Specific Functional Design
SGA	Substantial Gainful Activity
SH	State Hospitals (Now called Developmental Centers 1/2000)
SIS	Satisfactory Immigration Status
SIU	Special Investigative Unit
SKEY	Smart KEY (mnemonic of First Data Bank's Smart Key)

SLD	Similar Legal Device
SLIAG	State Legalization Impact Assistance Grant
SLMB	Special Low-Income Medicare Beneficiary Program
SMA	Scheduled Maximum Allowance
SMI	Serious Mental Illness
SNA	System Network Architecture
SNF	Skilled Nursing Facility (Nursing Facility Level B)
SO	Services Only
SOC	Share Of Cost
SOFP	State Only Family Planning
SP-DED	State Programs Disability Evaluation Division
SPC	Short Paid Claims
SPE	Single Point of Entry (to sign up for Medi-Cal or Healthy Families, etc.)
SPECT	Single Photon Emission Computed Tomography
SPH	Solano Partnership Health Plan (start date 4/1/94)
SPR	System Performance Review
SPR	Special Program Report
SQL	Structured Query Language (used to access DB2 files)
SS	Social Security
SSA	Social Security Administration
SSI	Supplemental Security Income
SSI/SSP	Supplemental Security Income/State Supplemental Payment
SSN	Social Security Number
SSP	State Supplemental Payment
STC	Specific Therapeutic Class (part of the Smart Key)
STI	Sexually Transmitted Infection
STP	Special Treatment Programs
STR	Drug Strength (part of the Smart Key)
STR	Systems Trouble Report
SUEM	Source User Edit Module
SURS	Surveillance Utilization Review System
SVR	System Variance Report
TANF	Temporary Assistance for Needy Families
TAR	Treatment Authorization Request
TB	Tuberculosis
TC	Transitional Care
TCM	Targeted Case Management
TCN	TAR Control Number
TCP/IP	Transmission Control Protocol/Internet Protocol
TEVS	Testing IEVS (for county testing and training purposes)
TIC	Transitional Inpatient Care
TIN	Taxpayer Identification Number
TLA	Three-Letter Acronym
TMC	Transitional Medi-Cal
TMF	TAR Master File
TMJ	TransMandibular Jaw
TMS	Tape Management System
TOS	Type of Service
TPA	Tissue Plasminogen Activator
TPL	Third Party Liability
TPN	Total Parenteral Nutrition
TPQY	Third Party Query (SSA Inquiry)
TSD	Technical System Design
TSO	Time Share Option
TSU	Technical Support Unit

TST	Test(ing)
TRS	Temporary Resident Status (Under IRCA of 1986)
TTG	Toll-free Telephone Group
U	Unemployed parent
UA	Units digit of Aid code
UB-92	Uniformed Billing (1992) codes
UDUU	Unit Dose/Unit of Use (part of the Smart Key)
UG	User Group
UI	Unemployment Insurance
UME	Unusually Medical Expenses
UP	Unemployed Parent
UPC	Universal Product Code
UPIN	Universal Provider Identification Number
UPS	Uninterruptible Power Supply
URVG	Uniform Relative Value Guide (for anesthesia codes unit values)
USC	United States Code
UTI	Urinary Tract Infections
VC	Vendor Code
VDTS	Voice Drug TAR System
VFC	Vaccines For Children
VOLAG	Voluntary Resettlement Agency
VOLSER	Volume Serial Number
VRU	Voice Response Unit
VTAM	Virtual Telecommunications Access Method
W & I	California Welfare and Institutions Code
WAN	Wide Area Network
WCAB	Workers Compensation Appeals Board
WIC	Women, Infants, and Children Welfare persons receiving TMC due to reuniting of spouses or marriage
WTD	Week To Date
XO	Medicare Crossover (Both Medicare and Medi-Cal)
XOVER	Medicare Crossover (Both Medicare and Medi-Cal)
YTD	Year To Date

APPENDIX Y. SUMMARY OF CHANGES FROM 35B-FILE TO 35C-FILE.

The following table identifies the key changes made to the S-35B format, to derive the new S-35C format. Please refer to the Copybook and S-35C Data Element Dictionary for layout and reporting requirements.

Field Name	Change from S-35B to S-35C
File LRECL	Expanded: from 25,154 to 31,164 bytes
Maximum Record Length	Expanded: from 25,150 to 31,160 bytes (data only)
Record Header	Expanded: from 400 to 470 bytes
Detail Segment	Expanded: from 250 to 310 bytes
Billing Provider Number	Expanded: from 9 to 10 bytes
Billing Provider Owner Number	Added
Billing Provider Location Number	Added
Special Processing Type	Added
Special Program Type	Added
COBA ID	Added
Payer Sequence Code (aka Payer Responsibility Code)	Added
Primary Diagnosis	Expanded: from 6 to 7 bytes
Secondary Diagnosis	Expanded: from 6 to 7 bytes
Primary Surgery Code	Expanded: from 5 to 7 bytes
Primary Surgery Code Procval Indicator	Added
Secondary Surgery Code	Expanded: from 5 to 7 bytes
Secondary Surgery Code Procval Indicator	Added
Admitting/Facility Provider Number	Added
Detail Medi-Cal Allowed Amount	Added: redefines the Detail Medi-Cal Paid

	Amount
Procval Indicator	Added
Procedure Type	Added
Inpatient Local Code	Added
NCPDP Reject Code (aka OHC Reject Code)	Added
UPN Number	Added
Drug Procedure Type	Added
Drug Procedure Code	Added
OHC Copay Amount	Added
Part D OHC Copay Amount	Added: redefines the OHC Copay Amount
Prescribing/Referring/Rendering Provider Number	Deleted: replaced by Referring/Prescribing Provider Number and Rendering/Operating Provider Number in the Detail segments
Prescribing/Referring/Rendering Provider Taxonomy	Deleted
Referring/Prescribing Provider Number	Added
Referring/Prescribing Provider Taxonomy	Added
Rendering/Operating Provider Number	Added
Rendering/Operating Provider Taxonomy	Added
Rendering/Operating Provider Owner Number	Added
Additional Fee	Added
Enhanced Therapeutic Class (ETC)	Added: redefines the SmartKey field
Drug Refill Number	Expanded: from 1 to 2 bytes
Part D Excluded Drug Indicator	Added
Dispensing Fee Code	Added
Revenue Type Code	Added
Revenue Code	Added
Financial Indicator	Added

Updated:

Funding Indicator	Added
Detail Aid Category	Added